Harvard Pilgrim Health Care

Benefit Handbook

The Harvard Pilgrim Independence Plan[sm]

For Group Insurance Commission Members

Effective July 1, 2008

Commonwealth of Massachusetts
Group Insurance Commission

This benefit plan is provided to you by the Group Insurance Commission (GIC) on a self-insured basis. Harvard Pilgrim Health Care has arranged for the availability of a network of health care Providers and will be performing various benefit and claim administration and case management services on behalf of the GIC. Although some materials may reference you as a Member of one of Harvard Pilgrim Health Care's products, the GIC is the insurer of your coverage.

Effective Date: July 1, 2008
Form No. 461 cc1512/gic/ma 07/08

INTRODUCTION

Welcome to the Harvard Pilgrim Independence Plan[sm] (the Plan). Thank you for choosing this Plan to help you meet your health care needs.

The health care services under this Plan are administered by Harvard Pilgrim Health Care (HPHC) through its Provider network. The Harvard Pilgrim Independence Plan is a self-insured health benefits plan for the Group Insurance Commission (GIC). The GIC is financially responsible for this Plan's health care benefits. HPHC provides benefits, claims administration and case management services on behalf of the GIC as outlined in this *Benefit Handbook, Schedule of Benefits* and the *Prescription Drug Brochure.*

Under the Plan, you can use either HPHC's network of Participating Providers or use Providers of your choice outside of the HPHC network to obtain these services. You have one set of Covered Services under the Plan. If a benefit limit applies, HPHC calculates your utilization for that benefit based on the Covered Services you have received from both Participating Providers and Non-Participating Providers. Although coverage is provided for both types of Providers, services obtained from Participating Providers generally have a lower Member cost.

If you choose to receive Covered Services from a provider or at a facility that is not a Participating Provider, your benefits will be covered at the *Out-of-Network* level.

Under this Plan, the GIC provides the covered health care services described in this *Benefit Handbook*, your *Schedule of Benefits* and the Prescription Drug Brochure.

Notice: HPHC uses clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of any HPHC clinical review criteria that is applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723.**

You may call the HPHC Member Services Department if you have any questions. HPHC values your input and would appreciate any comments or suggestions you may have. Member Services staff are available to help you with questions about the following:

- Your Benefit Handbook, the *Schedule of Benefits,* and the *Prescription Drug Brochure*
- Your In-Network and Out-of-Network benefits
- Enrollment
- Claims
- Provider information
- Requesting a Provider Directory
- Requesting a Member kit
- Requesting ID cards
- Registering a concern

The Member Services Department phone number is 1-888-333-4742. You may also email them at **WWW.HARVARDPILGRIM.ORG**, or write to them at the following address:

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

Deaf and hearing-impaired Members who own or have access to a Teletypewriter (TTY) may communicate directly with the Member Services Department by calling HPHC's TTY machine at **1-800-637-8257**.

Non-English speaking Members may also call the HPHC Member Services Department at **1-888-333-4742** with questions. HPHC offers free language interpretation services in more than 120 languages.

[Spanish]

Los miembros que no dominan el inglés pueden llamar al Departamento de servicios para miembros de Harvard Pilgrim Health Care al 1-888-333-4742, donde se responderá a sus preguntas. El Plan ofrece un servicio de interpretación gratuito en más de 120 idiomas.

[Russian]

Те, кто не владеет английским языком, могут также получить ответы на свои вопросы, позвонив по телефону 1-888-333-4742 в отдел обслуживания медицинского центра Harvard Pilgrim. Данный план предоставляет бесплатные услуги по обеспечению устного перевода более, чем на 120 иностранных языков.

[Arabic]

كما يستطيع الأعضاء الغير الناطقين باللغة الإنجليزية أن يتصلوا بقسم خدمات الأعضاء بهيئة هارفارد بيلجريم (Harvard Pilgrim) للعناية الصحية ، وذلك للحصول على الرقم 1-888-333-4742 على إجابات لاستفساراتهم. ويقدم البرنامج خدمات ترجمة مجانية بأكثر من 120 لغة.

[Portuguese]

Os membros que não falarem inglês também podem telefonar para o Departamento dos Serviços de Saúde Harvard Pilgrim para membros através do número 1 888 333 4742, de forma a obterem os esclarecimentos pretendidos. Este plano oferece serviços de interpretação gratuitos em mais de 120 idiomas.

[French]

Harvard Pilgrim Health Care propose des services d'interprétation gratuits dans plus de 120 langues pour répondre aux questions des membres qui ne parlent pas anglais. Pour utiliser ce service, appelez la section des services aux membres au 1-888-333-4742.

[Greek]

Τα Μέλη που δε μιλούν Αγγλικά μπορούν επίσης να τηλεφωνήσουν στο Τμήμα Εξυπηρέτησης Μελών του Harvard Pilgrim Health Care στον αριθμό 1-888-333-4742 για τυχόν ερωτήσεις. Το Πρόγραμμα παρέχει δωρεάν ξενόγλωσσες υπηρεσίες διερμηνείαςγια περισσότερες από 120 γλώσσες.

[Haitian Creole]

Manm yo ki pa pale Angle ka rele Depatman Sèvis Manm Harvard Pilgrim Health Care tou nan 1-888-333-4742 pou jwenn repons a keksyon yo. Plan an ofri sèvis entèpretasyon gratis nan plis ke 120 lang.

[Italian]

I Partecipanti che non parlano inglese possono anche rivolgere le proprie domande al Reparto Servizi Partecipanti dell'Harvard Pilgrim Health Care, chiamando il numero 1-888-333-4742. Il Piano offre servizi di interpretariato gratuiti in oltre 120 lingue.

[Traditional Chinese]

不說英語的會員亦可致電 1-888-333-4742，請 Harvard Pilgrim 醫療保健的 會員服務部門回答所提出的問題。該計劃免費提供120多種語言的翻譯服務。

[Lao]

ສະມາຊິກ ທັງ ຫລາຍ ທີ່ ປາກ ພາສາ ອັງກິດ ບໍ່ ຄ່ັນກໍ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະແນກ ບໍລິການ ລູກ ຄ້າ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ **Harvard Pilgrim** ໄດ້ ໂດຍ ໂທ ໄປ ຫາ **1-888-333-4742** ເພື່ອ ຂໍ ຊາບ ຄໍາ ຕອບ ຂອງ ຄໍາ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນ້ີ ຂໍ ສະເໜີ ບໍລິການ ແປ ພາສາ ໃນ ຫລາຍ ກວ່າ **120** ພາສາ ໂດຍ ່ ຄິດ ຄ່າ ບໍລິການ ໃດໆ ທັງ ສ້ິນ.

[Cambodian]

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Health Care លេខ **1-888-333-4742**
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I. BENEFIT HANDBOOK

SECTION A. ABOUT THE HARVARD PILGRIM INDEPENDENCE PLAN

The Harvard Pilgrim Independence Plan (the Plan) provides you with two levels of benefits known as *In-Network* coverage and *Out-of-Network* coverage.

You receive *In-Network* coverage when your care is provided by a Participating Provider. Additionally, care received in a Medical Emergency is always covered at the In-Network level. Participating Providers are under contract to provide care to Plan Members, and they have agreed to accept HPHC payment plus any applicable Member Cost as payment in full. There are certain specialized services that must be received at designated Participating Providers, called "Centers of Excellence" to receive In-Network coverage. Please see Section I.A.9. ("Centers of Excellence") for further information.

You receive *Out-of-Network* coverage when you obtain Covered Services from Non-Participating Providers. HPHC does not have agreements or contracts with Non-Participating Providers. The Plan pays a percentage of the cost of care you receive from Non-Participating Providers. The Plan's percentage payment is based on the Reasonable Charges for such services. You are responsible for the remainder of the Reasonable Charge, any amount above the Reasonable Charge, and any applicable Member Cost.

Your *In-Network* and *Out-of-Network* coverage is described further below. Please see your *Schedule of Benefits* as well as this *Benefit Handbook* to see if a Copayment, Coinsurance or Deductible applies to your coverage.

1. HOW TO USE THIS BENEFIT HANDBOOK

a. Why This Benefit Handbook Is Important

We wrote this *Benefit Handbook* so that you would understand your coverage. It explains what you must do to obtain coverage for services and what you can expect under the Plan. It is also your guide to the most important things you need to know. These include:

- What is covered;
- What is not covered;
- Any limits or special rules for coverage;
- Any Prior Plan Approval or Notification requirements; and
- Member Cost, which means any Copayments, Coinsurance, Deductibles or Benefit Reductions you must pay.

Your Prescription drug benefits are listed in the Prescription Drug Brochure. Your Schedule of Benefits summarizes the specific benefits provided by the GIC. You should keep and refer to this Benefit Handbook for more detailed information on benefits and coverage.

b. Words With Special Meaning

Some words in this *Benefit Handbook* have a special meaning. When we use one of these words, we start it with a capital letter. We list each of these words and their meanings in the Glossary at the end of this *Benefit Handbook*.

c. How To Find What You Need To Know

The Table of Contents will help you find what you need to know.

We also put the most important things first. For example, in this section we tell you how your coverage works. In the next section we tell you what is covered. Specific benefit limitations appear after the benefit to which they relate in this *Benefit Handbook* and the *Schedule of Benefits*. General benefit exclusions are listed at the end of the Covered Services Section (Section B). Any Copayment, Coinsurance, Deductibles or Benefit Reductions for which you are responsible are also listed in this *Benefit Handbook* and the *Schedule of Benefits*.

2. HOW THE PLAN WORKS

a. In-Network and Out-of-Network Benefits

The Plan offers different levels of coverage, referred to in this document as "In-Network" and "Out-of-Network" coverage.

In-Network coverage is available when you receive Covered Services from a Participating Provider. Your out-of-pocket cost is generally lower for In-Network coverage. In-Network coverage applies to Participating Providers in Massachusetts, Maine, New Hampshire, Connecticut, Rhode Island,

Vermont and a large number of providers in Harvard Pilgrim's Affiliated National Network around the country.

Out-of-Network coverage is available for Covered Services you receive from Non-Participating Providers. Although your Out-of-Pocket cost is generally higher for Out-of-Network coverage, the Out-of-Network benefit allows you to obtain Covered Services from a wider array of providers. Please see Section A.4. for more information on your Out-of-Network coverage.

Please note: Members are responsible for obtaining Prior Plan Approval from the Plan for some Out-of-Network services. Please see Section A.6. on page 12 for information on the Prior Plan Approval Program, including a list of the specific services that require Prior Approval.

To request Prior Approval, please call:

- 1-800-708-4414 for Medical Services
- 1-888-777-4742 for Mental Health and Substance Abuse Services

b. Selecting a Participating Provider from the Provider Directory

Participating Providers include a large number of specialists and health care institutions in Massachusetts and surrounding states. HPHC publishes a GIC Provider Directory that lists the Participating Providers by geographic area and languages spoken.

The online Provider Directory for the Harvard Pilgrim Independence Plan at the HPHC Internet site can be found at **www.harvardpilgrim.org.** This site also provides links to several physician profiling sites including one maintained by the Commonwealth of Massachusetts Board of Registration in Medicine at **www.massmedboard.org**.

You may obtain a free copy of the GIC Provider Directory from HPHC's Member Services Department by calling 1-888-333-4742 or you may access the Directory online by visiting HPHC's internet site, **www.harvardpilgrim.org**.

Please note: The physicians and other medical professionals in HPHC's provider network participate through contractual arrangements that can be terminated either by a provider or by HPHC at any time. In addition, a provider may leave HPHC's network because of retirement, relocation or other reasons. This means that HPHC cannot guarantee that the physician you choose will continue to participate in HPHC's network for the duration of your Plan Membership.

c. Specialists

HPHC has worked with the analytical tools and statistical expertise of industry leaders to "profile" HPHC Participating Providers in twelve high-volume specialties in Massachusetts. The goal of this work was to compare the relative effectiveness of doctors in the same specialty in treating similar patients. Based on these comparisons, specialists were grouped into three levels, known as Tier 1 Providers, Tier 2 Providers and Tier 3 Providers. Quality of care was evaluated based on clinical guidelines for recommended care. Cost efficiency was evaluated by comparing how much it cost each specialist to treat Harvard Pilgrim members for similar conditions. Specialists whose scores were rated "excellent" were placed in Tier 1. Specialists whose scores were rated "good", or had insufficient cost and/or quality information to measure were placed in Tier 2. Specialists whose scores were rated "standard" were placed in Tier 3.

In-Network outpatient services provided by Tier 1 Providers are subject to a $15 Tier 1 Copayment.

In-Network outpatient services provided by Tier 2 Providers are subject to a $25 Tier 2 Copayment.

In-Network outpatient services provided by Tier 3 Providers are subject to a $35 Tier 3 Copayment.

The twelve specialties that have been evaluated and tiered into three levels are:

- Allergy/Immunology, including Pediatric Allergy, and Pediatric Immunology
- Cardiovascular Disease, including Cardiology, Clinical Cardiac Electrophysiology, Interventional Cardiology and Pediatric Cardiology
- Dermatology, including Pediatric Dermatology
- Endocrinology
- Gastroenterology, including Pediatric Gastroenterology
- General Surgery, including Abdominal Surgery, Pediatric Surgery, Peripheral Vascular Surgery, Proctology, Surgery, Colon and Rectal Surgery and Vascular Surgery

- Neurology, including Clinical Neurophysiology
- Obstetrics/Gynecology
- Ophthalmology, including Pediatric Ophthalmology
- Orthopedics, including Orthopedic Surgery, Hand Surgery and Pediatric Orthopedics
- Otolaryngology
- Rheumatology

Please refer to the GIC Provider Directory or view the directory online at **www.harvardpilgrim.org** to determine what tier your specialty provider is in. Please refer to Section A.3 on pages 9-10 for more information on Tier 1 Copayments, Tier 2 Copayments and Tier 3 Copayments.

d. Non-tiered Providers:

Non-tiered Providers include Harvard Pilgrim Providers who have not been rated for quality and/or cost-efficiency or assigned to a tier. These include:

- All Harvard Pilgrim Providers (Massachusetts and other states) in: internal, adolescent and geriatric medicine; family and general practice; pediatrics; physical, speech and occupational therapy; chiropractic; audiology; optometry; and midwives and nurse practitioners. These Providers have the same Copayment as Tier 1 specialists.
- Massachusetts physicians in the 12 tiered specialties for whom there was insufficient data to measure. These specialists have the same Copayment as Tier 2 specialists.
- Non-Massachusetts physicians in the 12 tiered specialties. These specialists have the same Copayment as Tier 2 specialists.
- All other Harvard Pilgrim specialists (Massachusetts and other states) outside of the 12 tiered specialties. These specialists have the same Copayment as Tier 2.

Important note about tiered and non-tiered Providers: Some Providers in tiered specialties such as Cardiology, Gastroenterology and Obstetrics/Gynecology may also be Providers in Internal Medicine, Pediatrics or other primary care specialties. For these Providers, the Copayment for the tiered specialty may apply. For example, if you visit a Tier 2 Gastroenterologist who also practices internal medicine, you will pay the Tier 2 Copayment for most services.

Providers tier assignments will remain the same for the duration of your plan year, which begins on July 1 and ends the following June 30.

e. Provider Fees for Special Services

The Plan covers all of the benefits listed in this Benefit Handbook. However, certain physician practices charge extra fees for special services or amenities, in addition to the benefits covered by the Plan. Examples of such special physician services might include: telephone access to a physician 24-hours a day; waiting room amenities; assistance with transportation to medical appointments; guaranteed same day or next day appointments when not Medically Necessary; or providing a physician to accompany a patient to an appointment with a specialist. Such services are not covered by the Plan. The Plan does not cover fees for any service that is not listed as a Covered Service in this Handbook.

In considering arrangements with physicians for special services, Members should understand exactly what services are to be provided, the Member Cost for such services, and whether those services are worth the fee the Member must pay.

f. Medical Emergency Services

You are always covered for care in a Medical Emergency. In a Medical Emergency you may obtain services from a physician, a hospital or a hospital emergency room. You are also covered for ambulance transportation to the nearest hospital that can provide the care you need. Please see your *Schedule of Benefits* for information on the Member Cost that applies to the different types of emergency care.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

A Medical Emergency means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are:

- Heart attack or suspected heart attack
- Stroke
- Shock
- Major blood loss
- Choking
- Severe head trauma
- Loss of consciousness
- Seizures
- Convulsions

Please remember that if you are hospitalized you must call the Plan within 48 hours or as soon as you can. If notice of hospitalization is given to the Plan by an attending emergency physician, no further notice is required.

3. HOW YOUR IN-NETWORK COVERAGE WORKS

Your Plan is subject to the following *In-Network* Member Cost for medical coverage. (**Please note**: *In-Network* Member Cost for mental health and substance abuse services is included in Section B.6. on page 24, "Mental Health and Substance Abuse Services".)

There are a certain specialized services that must be received at designated Participating Providers, called "Centers of Excellence" to receive In-Network coverage. Please see Section I.A.9. ("Centers of Excellence") for further information.

a. Copayments

A Copayment is a fixed dollar amount that you must pay for certain Covered Services. Copayments are due at the time of service or when billed by the Provider. The Copayment amounts that apply to your Plan are stated in your *Schedule of Benefits*.

Your Plan has three levels of Copayments that apply to outpatient services you receive while a Member of the Plan. These are known as Tier 1 Copayments, Tier 2 Copayments, and Tier 3 Copayments.

1) Tier 1 Copayments

The Tier 1 Copayment is $15 per visit. The Tier 1 Copayment applies to covered outpatient services for specific Providers with an "Excellent" rating. The physician rating of "Excellent" is based on quality and cost effectiveness rankings.

The Tier 1 Copayment applies to select Providers listed in Section A.2.c. titled "Specialists".

Certain Non-tiered Providers, as described in section A.2.d., that are not rated based on cost and quality standards, are also subject to the Tier 1 Copayment of $15 per visit. These specialties are listed below:

- Internal, Adolescent and Geriatric Medicine
- Family and General Practice
- Pediatrics
- Physical, Speech and Occupational Therapy
- Chiropractic
- Audiology
- Optometry
- Midwives and Nurse Practitioners

The following Services will always be subject to the Tier 1 Copayment, even if you receive them from a Tier 2 or Tier 3 Provider.

- Routine well physical examinations
- Routine eye examinations
- Annual routine gynecological examinations
- Physical and occupational therapies
- Early Intervention services
- Immunizations, when billed as part of an office visit
- Infertility treatment using advanced reproductive technologies or therapeutic donor insemination
- Vision and auditory screening for children
- Nutrition counseling and health education
- Voluntary termination of pregnancy
- Voluntary sterilization
- Outpatient mental health and substance abuse services (Please note: The Member Cost for group therapy visits for outpatient mental health and substance abuse is lower than the Tier 1 Copayment. Please refer to section B.6.b. titled "Outpatient Services - Mental Health and Substance Abuse Services".

2) Tier 2 Copayments

The Tier 2 Copayment is $25 per visit. The Tier 2 Copayment applies to covered outpatient services for specific providers with a "Good" rating. The Physician rating of "Good" is based on quality and cost effectiveness rankings. The Tier 2 Copayment applies to select Providers noted in Section A.2.c. titled "Specialists".

Certain Non-tiered Providers, as described in section A.2.d., that are not rated based on cost and quality standards, are also subject to the Tier 2 Copayment of $25 per visit. These Providers are listed below:

- Massachusetts physicians in the 12 tiered specialties for whom there was insufficient data to measure. These specialists have the same Copayment as Tier 2 specialists.
- Non-Massachusetts physicians in the 12 tiered specialties. These specialists have the same Copayment as Tier 2 specialists.
- All other Harvard Pilgrim specialists (Massachusetts and other states) outside of the 12 tiered specialties. These specialists have the same Copayment as Tier 2.

3) Tier 3 Copayments

The Tier 3 Copayment is $35 per visit. The Tier 3 Copayment applies to covered outpatient services for specific Providers with a "Standard" rating. The Physician rating of "Standard" is based on quality and cost effectiveness standings. The Tier 3 Copayment applies to select Providers noted in Section A.2.c. titled "Specialists".

4) Hospital Inpatient Copayment

$300 per admission up to a maximum of $1,200 per Member per calendar year.

5) Surgical Day Care Copayment

$100 per admission up to a maximum of $400 per Member per calendar year.

6) Emergency Room Copayment

$50 per visit. This Copayment is waived if admitted directly to the Hospital from the emergency room, in which case you are responsible for the Hospital Inpatient Copayment

b. Coinsurance

Coinsurance is a percentage of the Covered Charge for certain Covered Services that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in this *Benefit Handbook* and the *Schedule of Benefits*.

In-Network skilled nursing facility services are subject to 20% Coinsurance; Coronary Artery Disease program services are subject to a 10% Coinsurance.

c. Services Provided by a Disenrolled or Non-Participating Provider

1) Pregnancy

If you are a female Member in your second or third trimester of pregnancy and the Participating Provider you are seeing in connection with your pregnancy is involuntarily disenrolled, for reasons other than fraud or quality of care, you may continue to receive *In-Network* coverage for services delivered by the disenrolled Provider, under the terms of this *Benefit Handbook* and your *Schedule of Benefits*, for the period up to, and including, your first postpartum visit.

2) Terminal Illness

A Member with a Terminal Illness whose Participating Provider in connection with such illness is involuntary disenrolled for reasons other than fraud or quality of care, may continue to receive *In-Network* coverage for services delivered by the disenrolled Provider, under the terms of this *Benefit Handbook* and the *Schedule of Benefits*, until the Member's death.

3) New Membership

If you are a new Member, the Plan will provide *In-Network* coverage for services delivered by a physician who is not a Participating Provider, under the terms of this *Benefit Handbook* and your *Schedule of Benefits*, for up to 30 days from your effective date of coverage if the physician is providing you with an ongoing course of treatment.

Services received from a disenrolled or Non-Participating Provider, as described in paragraphs 1, 2, and 3 above, are only covered when the physician agrees to:

- Accept reimbursement from the Plan at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Member in an amount that would exceed the cost sharing that could have been imposed if the Provider had not been disenrolled;

- Adhere to the quality assurance standards of HPHC and to provide the Plan with necessary medical information related to the care provided; and
- Adhere to the Plan's policies and procedures, obtaining Prior Plan Approval and providing Covered Services pursuant to a treatment plan, if any, approved by the Plan.

4. HOW YOUR OUT-OF-NETWORK COVERAGE WORKS

Your *Out-of-Network* coverage applies whenever you obtain Covered Services from providers who are not Participating Providers (also known as Non-Participating Providers). After you meet a yearly Deductible, the Plan pays a percentage of the Reasonable Charge of these Covered Services. You are responsible for paying the balance if the provider charge is more than the Reasonable Charge.

Certain specialized services must be received from designated Participating Providers, referred to as "Centers of Excellence," to be covered as In-Network benefits. (Please see Section I.A.9. "Centers of Excellence" for a list of these services.) If one of these services is received from a Provider that is not a Center of Excellence, coverage will be at the Out-of-Network benefit level.

Your Plan is subject to the following *Out-of-Network* Member Cost for medical coverage. (**Please note**: *Out-of-Network* Member Cost for mental health and substance abuse services is included in Section.B.6. on page 24, "Mental Health and Substance Abuse Services"):

a. Out-of-Network Member Cost

Deductible for Medical Services: $150 per Member per calendar year and $300 per Family per calendar year

The Deductibles for medical care accumulate separately from the mental health and substance abuse Deductibles.

Please note: The following costs do not apply to the annual Deductible:

- Outpatient emergency room services
- Benefit Reductions
- Hearing aids

Copayments: $50 Emergency Room Copayment; $300 Hospital Inpatient Copayment if emergency admission.

Coinsurance: 20% of Covered Charges after the Deductible is met until the Out-of-Pocket Maximum is reached.

Benefit Reductions: $500 applied to any medical service that requires Notification or Prior Plan Approval if such Notification as described on page 15 or Prior Plan Approval as described on page 12, is not received.

Medical Out-of-Pocket Maximum: $3,000 per Member per calendar year, including Coinsurance and Deductible payments.

Separate Out-of-Pocket Maximums exist for medical care and mental health and substance abuse services.

Please note: The following does not apply to the Out-of-Pocket Maximum:

- Copayments
- Skilled nursing facility Coinsurance
- Prescription drug Copayments
- Benefit Reductions
- Any charges in excess of the Reasonable Charge.

b. Paying Out-of-Network Annual Deductibles

When you use a Non-Participating Provider, you must first satisfy the Deductible before the Plan begins paying benefits. This *Benefit Handbook* and the *Schedule of Benefits* specify the Deductible you must satisfy. Each Member must satisfy the per-person annual Deductible amount each calendar year. The Family Deductible is met when any combination of Members reaches the Family Deductible amount. When there is a Family Deductible, no Family Member will pay more than the per person annual Deductible. Any Deductible amount incurred for services rendered during the last three (3) months of a calendar year will apply toward the Deductible requirement for the next year, provided that the Member had continuous coverage under the Plan through the GIC at the time the charges in the prior year were incurred. Deductible amounts for all services are considered incurred as of the date of service.

c. Paying Out-of-Network Coinsurance

After the appropriate Deductible amount is met, you will be responsible for paying the Coinsurance amount. Deductible and Coinsurance amounts are listed in this *Benefit Handbook* and the *Schedule of Benefits*.

d. Charges in Excess of the Reasonable Charges

On occasion, a Non-Participating Provider may charge amounts in excess of the Reasonable Charges. In those instances, you will be financially responsible for the difference between the amount charged by a Non-Participating Provider and the amount the Plan allows.

5. OUT-OF-AREA COVERED SERVICES FROM OUR AFFILIATED NATIONAL NETWORK OF PROVIDERS

Through a partnership with a national provider network, you are able to receive Covered Services outside of the Enrollment Area with lower Member Cost than Out-of-Network coverage. The national network includes nearly 450,000 physicians and over 4,000 hospitals. To locate one of these Providers, log onto our website at **www.harvardpilgrim.org** or call Member Services at **1-888-333-4742**.

6. PRIOR APPROVAL PROGRAM

The Prior Approval Program is designed to make sure that the use of certain Covered Services is appropriate. If you use a Participating Provider, he or she will obtain Prior Plan Approval for you. You or your designee are responsible for obtaining Prior Plan Approval for these services only when you use a Non-Participating Provider. The Prior Approval Program benefits both the Plan and its Members by ensuring the appropriate use of health care services and reducing health care costs for providing health insurance.

The Prior Approval Program evaluates whether a procedure or service is Medically Necessary, including whether it is, and continues to be, provided in an appropriate setting. When Prior Plan Approval is obtained, the Plan will pay up to the full benefit limit stated in this *Benefit Handbook* and the *Schedule of Benefits* for the period and procedure or service approved. If Prior Plan Approval is not obtained, whenever you use a Non-Participating Provider, you will be responsible for paying the Benefit Reductions amount stated in this *Benefit Handbook* and the *Schedule of Benefits* in addition to any Copayments, Coinsurance and Deductibles. If the Plan determines at any point that a procedure or service is not Medically Necessary, no payments will be made for such procedures or services. You will be notified of the Plan's decision and you will be responsible for the entire cost of these procedures or services. Prior Plan Approval does not entitle you to benefits not otherwise payable under this *Benefit Handbook*.

To request Prior Approval, please call:

- **1-800-708-4414** for Medical Services
- **1-888-777-4742** for Mental Health and Substance Abuse Services

a. What procedures and services require Prior Plan Approval

The following is a list of procedures and services for which Prior Plan Approval is required. Unless otherwise stated below, Prior Plan Approval is required for these procedures and services regardless of where the procedure or service is delivered (for example, at a hospital, surgical day care facility, or physician's office.)

Procedures

- Blepharoplasty - plastic surgery on an eyelid especially to remove fatty or excess tissue. This procedure is sometimes done in conjunction with Ptosis repair when the excess tissue is due to a medical disease.
- Bone marrow transplant/stem cell transplant
- Breast implant removal
- Breast reduction mammoplasty
- Weight loss surgery (bariatric surgery)
- Laminectomy/Discectomy – procedures done on the vertebra in the back usually for disc disease
- Mandibular/Maxillary osteotomy – surgical procedures to realign the jaw, usually for patients with obstructive sleep apnea
- Medical treatment of temporomandibular joint (TMD) treatment
- Odontectomy - the removal of teeth by the reflection of a mucoperiosteal flap and excision of bone from around the root or roots before the application of force to effect the tooth removal
- Panniculectomy - a procedure to remove fatty tissue and excess skin from the lower to middle portions of the abdomen
- Port wine stain laser treatment
- Ptosis repair - a procedure to repair the sagging or a drooping of the upper eyelid such that the drooping eyelid impairs the vision as measured by a visual field test

- Reconstructive surgery and procedures (includes scar revision and other potential cosmetic services)
- Rhinoplasty – plastic surgery to change the shape or size of the nose
- Septoplasty – surgical procedure to correct defects or deformities of the nasal septum
- Uvulopalatopharyngoplasty (UPPP) - a surgical procedure to remove excess soft tissue surrounding the uvula, soft palate, and tonsils to create a wider opening in the back of the mouth to treat sleep apnea
- Varicose vein excision and ligation

Services

- Advanced reproductive technology (ART) - Includes the following services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer, intra-cytoplasmic sperm injection and donor egg procedures.
- Home health care, including home infusion and home hospice
- Infant formula
- Inpatient and Surgical Day Care dental care, extractions and oral or periodontal surgery
- Inpatient rehabilitation care, including inpatient pulmonary rehabilitation
- Inpatient skilled nursing care (SNF)
- Intra-facility admissions (transfers)
- Mental Health and Substance Abuse services
- Non-emergency ambulance transport
- Outpatient enteral nutrition
- Outpatient pulmonary rehabilitation
- Speech/language therapy

Please refer to Chart 1 below, to determine who is responsible for requesting approval for inpatient hospital, day surgery, or day hospitalization admissions.

Chart 1

Admitted by:	Admitted to:	Approval Responsibility:
Participating Provider	Participating Hospital	Participating Provider
Participating Provider	Non-Participating Hospital	Member
Non-Participating Provider	Participating Hospital	Member
Non-Participating Provider	Non-Participating Hospital	Member

b. How To Seek Prior Plan Approval

To seek Prior Plan Approval, please call:

- For medical services, call **1-800-708-4414**
- For all mental health and substance abuse services, call **1-888-777-4742**

For planned admissions to an *Out-of-Network* medical facility, you must contact the Plan in advance. To assure that the Prior Approval process will be completed in a timely manner, you should contact the Plan at least five (5) business days in advance of a planned admission. Prior Approval is not required for hospital admissions for maternity care or any service needed in a Medical Emergency. However, in the event of an emergency admission, the Plan must be contacted no more than 48 hours after admission or as soon as reasonably possible.

The following information will be requested:

- The Member's name
- The Member's ID number
- The treating Provider's name, address and telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For *Out-of-Network* inpatient admissions the following additional information must be given:

- The name and address of the facility where care will be received
- The admitting Provider's name, address and telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

c. What the Prior Approval Program Does

Once the Prior Plan Approval process has been initiated, the Prior Approval Program will evaluate the need for care. You and your attending physician will be notified of the Prior Approval Program's decision to approve or deny the Covered Services. During the course of services the Prior Approval Program will review your care with your Providers to make sure the services continue to be Medically Necessary. All decisions not to approve your services, including admission or the requested length of stay, will be reviewed by a qualified physician.

d. Effect of Prior Plan Approval on Coverage

For procedures or services that are approved, Covered Charges will be paid at the applicable rate stated in this *Benefit Handbook* and the *Schedule of Benefits*.

- If Prior Plan Approval is not obtained, you will not be covered if the Plan determines the procedure or service was not Medically Necessary.
- If Prior Plan Approval is not obtained, but it is determined that the procedure or service is Medically Necessary, the procedure or service will

be subject to Benefit Reductions, before the Plan begins coverage for the service.

The Benefit Reductions amount will not be applied to the Deductible or Out-of-Pocket Maximum. Prior Plan Approval does not entitle you to benefits not otherwise payable under this *Benefit Handbook*.

When the Prior Approval Program denies a coverage request, it will notify you and your Provider as soon as possible. Prior Plan Approval will be denied if it is determined that the treatment is not Medically Necessary. This might include, for example, (a) when treatment could be provided on an outpatient basis; (b) when the proposed level of inpatient care is not appropriate for your medical condition; or (c) when inpatient care is no longer necessary.

7. NOTIFICATION

The Plan requires that you or your designee notify HPHC prior to receiving certain services from a Non-Participating Provider.

When Notification is made, the Plan will pay up to the full benefit limit stated in this *Benefit Handbook* and your *Schedule of Benefits*. If Notification is not made in advance, whenever you use a Non-Participating Provider, you will be responsible for paying the Benefit Reductions amount stated in this *Benefit Handbook* and the *Schedule of Benefits* in addition to any Copayments, Coinsurance and Deductibles.

To notify the Plan, you should call: **1-800-708-4414.**

The following services require Notification:

- All medical admission to an inpatient facility, (including admissions for maternity care) except for those procedures or services previously noted in the Prior Plan Approval section.
- All Surgical Day Care Services, except for those procedures or services previously noted in the Prior Plan Approval section
- Human organ transplants, except for bone marrow or stem cell transplants (see Prior Plan Approval)
- Outpatient physical and occupational therapy services

For planned *Out-of-Network* admissions, you must notify the Plan in advance. To assure that Notification will be completed in a timely manner, you should contact the Plan at **1-800-708-4414** at least five (5) business days in advance of the admission. In the event of a Medical Emergency admission, you or your designee must notify the Plan within 48 hours or as soon as possible.

If either the Hospital or physician is a Non-Participating Provider, you are responsible for notifying the Plan.

8. WHEN YOU RECEIVE IN-NETWORK AND OUT-OF-NETWORK COVERAGE FOR THE SAME CONDITION

Under some circumstances you may receive services from both a Participating Provider and a Non-Participating provider when receiving care. When this occurs, the determination as to whether you receive coverage at the In-Network or Out-of-Network level depends upon the participation status of the individual service provider

Please refer to Chart 2, below, as a guideline of the benefit payment levels when using various Provider combinations.

9. CENTERS OF EXCELLENCE

Certain specialized services are only covered at the In-Network benefit level when received from designated Participating Providers with special training, experience, facilities or protocols for the service. HPHC refers to these Providers as "**Centers of Excellence**." Centers of Excellence are selected by the HPHC based on the findings of recognized specialty organizations or government agencies such as Medicare.

In order to receive In-Network coverage for the following service[s] you must obtain care at a Participating Provider that has been designated as a Center of Excellence:

- Weight loss surgery (bariatric surgery)

IMPORTANT NOTICE: If you choose to receive treatment for the above service[s] at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level. A list of Centers of Excellence may be found in the Provider Directory. Members may view the Provider Directory at WWW.HARVARDPILGRIM.ORG or contact the Member Services Department at 1-888-333-4742 to verify a Provider's status.

HPHC may revise the list of services that must be received from a Center of Excellence upon thirty days notice to Members. Services or procedures may be added to the list when HPHC identifies services in which significant improvements in the quality of care may be obtained through the use of selected providers. Services or procedures may be removed from the list if HPHC determines that significant advantages in quality of care will no longer be obtained through the use of a specialized panel of Providers.

Chart 2

	Admitted by: **Participating Provider**	Admitted by: **Non-Participating Provider**
Admitted to: **Participating Hospital**	Hospital - *In-Network* benefit payment level Physician - *In-Network* benefit payment level	Hospital – *In-Network* benefit payment level Physician - *Out-of-Network* benefit payment level
Admitted to: **Non-Participating Hospital**	Hospital - *Out-of-Network* benefit payment level Physician - *In-Network* benefit payment level	Hospital – *Out-of-Network* benefit payment level Physician - *Out-of-Network* benefit payment level

SECTION B. COVERED SERVICES

In this section, you will find just about everything you need to understand your Plan benefits. This includes: what is covered, what is not covered, and any limitations on coverage. Each Covered Service section describes your basic benefit. It also tells you whose responsibility it is to provide Notification or obtain Prior Plan Approval, if required for a particular service.

You have one set of Covered Services per calendar year. If the Covered Service has benefit limits, you are restricted to those limits regardless of whether you receive care *In-Network, Out-of-Network* or both. For example, if the Covered Service is limited to ten visits and you receive nine visits *In-Network* and one visit *Out-of-Network*, then you will have reached your benefit limit and will no longer have coverage for that benefit for the remainder of that calendar year.

1. BASIC REQUIREMENTS FOR COVERAGE

To be covered, all services and supplies must be:

- Medically Necessary;
- Received while a Member of the Plan;
- Listed in Section B. on pages 17-35, "Covered Services" and not excluded in Section B.9. on pages 36-37, "Exclusions."

Please see your *Schedule of Benefits* as well as this *Benefit Handbook* for any special limits or exclusions from coverage.

In-Network services must be obtained from a Participating Provider. The only exceptions are care needed in a Medical Emergency.

Out-of-Network services may be provided by a Non-Participating Provider.

2. INPATIENT CARE

The Plan covers the following inpatient services:

- Semi-private room and board
- Doctor visits, including consultation with specialists
- Medications
- Lab and x-ray services
- Intensive care
- Surgery, including related services
- Anesthesia, including the services of a nurse-anesthetist
- Radiation therapy
- Physical therapy, occupational therapy and speech therapy

The type of coverage that applies to a Hospital admission depends on the participation status of both the admitting physician and the Hospital. Please refer to Chart 2 on page 16 as a guideline of the benefit payment levels when using various Provider combinations.

All inpatient admissions including Surgical Day Care services require you or your designee to *notify* HPHC in advance of the need for such services. An admission includes the transfer from one inpatient facility to another.

If you are readmitted to an In-Network acute care hospital or behavioral health hospital within 30 calendar days of a discharge, your second Inpatient Copayment will be waived. Readmission does not have to be to the same hospital or for the same condition. For example, if you were admitted to a hospital on February 2nd and discharged on February 5th you would pay your Inpatient Copayment. If on February 20th you were readmitted to a hospital, your Inpatient Copayment will be waived. However, if you are readmitted to the hospital on March 7th, you are responsible for paying your Inpatient Copayment. This waiver is limited to a calendar year basis. For example, if you were discharged from a hospital on December 16th, you would pay your Inpatient Copayment. If you are readmitted to a hospital on January 4th, you would be responsible for your Inpatient Copayment, since it occurs in a new calendar year. **Please note: When you are billed for an Inpatient Copayment that should be waived, you must notify Harvard Pilgrim's Member Services Department so that we may adjust your claims.**

In-Network coverage applies when you use a participating Hospital. A Participating Provider will arrange the admission and provide Notification or obtain Prior Plan Approval, whichever is appropriate.

Out-of-Network coverage applies when you are using a Non-Participating Provider. You are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, in advance of such admission by calling: **1-800-708-4414**.

For further information about the Prior Plan Approval process or Notification process, please refer to Sections A.6. on page 12 or A.7. on page 15.

Specific inpatient care benefits are described below.

a. Acute Hospital Care

The Plan covers acute hospital care to the extent Medically Necessary. There is no limit on the number of Medically Necessary days covered.

Prior Plan Approval or Notification:

- If you are using a Participating Provider, (s)he will arrange the admission and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: 1-800-708-4414.

In order to be eligible for In-Network coverage, the following service[s] must be received at a Center of Excellence:

- Weight loss surgery (bariatric surgery)

Please see Section I.A.9. ("Centers of Excellence") for further information.

Member Cost:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

b. Skilled Nursing Facility Care

The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Such coverage is provided only when you need daily skilled nursing care or rehabilitative services that must be provided in an inpatient setting. These services are limited to a maximum of 45 days per Member per calendar year.

Prior Plan Approval:

- If you are using a Participating Provider, (s)he will arrange the admission and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

- *In-Network*: Member pays 20% of the Reasonable Charge.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge. Member Cost for skilled nursing facility services does not apply to the Out-of-Network Out-of-Pocket Maximum.

c. Inpatient Rehabilitation Services

The Plan covers care in a health care facility licensed to provide rehabilitative care on an inpatient basis. Rehabilitative care includes physical, speech and occupational therapies.

Prior Plan Approval

- If you are using a Participating Provider, (s)he will arrange the admission and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS FOR ALL INPATIENT CARE:

- Personal items, including telephone and television charges
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Rest or Custodial Care
- Blood or blood products
- Charges after your Hospital discharge
- Charges after the date on which your membership ends

3. OUTPATIENT CARE

The Plan covers outpatient care that you receive from a Provider at a doctor's office, clinic or Hospital.

Member Cost:

Office visits:

- *In-Network*: Member pays the applicable Copayment

Tier 1 Copayment: $15 per office visit

Tier 2 Copayment: $25 per office visit

Tier 3 Copayment: $35 per office visit

- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Emergency Room visits:

- *In-Network:* Member pays a $50 Copayment per ER visit. This Copayment is waived if you are admitted directly from the emergency room, in which case you will be responsible for the $300 Hospital Inpatient Copayment.
- *Out-of-Network:* Member pays a $50 Copayment per ER visit. This Copayment is waived if you are admitted directly from the emergency room, in which case you will be responsible for the $300 Hospital Inpatient Copayment.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

a. Preventive Care in the Doctor's Office

The Plan covers preventive care according to your individual medical needs. Covered preventive care includes: physical examinations; immunizations; vision and hearing screening; mammograms; health education; and nutritional counseling (limited to three visits per calendar year except as needed for the treatment of diabetes).

Also covered are Medically Necessary diagnostic screening and tests, including, but not limited to, the following: hereditary and metabolic screening at birth; newborn hearing screening test; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, and urinalysis; annual cytological screenings; and mammograms, including a baseline mammogram for women between the ages of thirty-five and forty, and an annual mammogram for women forty years of age and older.

Covered pediatric care includes: physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals: at least six visits per year are covered for a child from birth to age one; at least three visits per year are covered for a child from age one to age two; at least one visit per year is covered for a child from age two to age six.

1) Routine Physical Examinations

The Plan covers routine physical examinations. School, sports, camp and premarital examinations are also covered.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: Member pays a $15 Tier 1 Copayment per office visit. There is no Member Cost for mammograms or Pap smears when provided as part of a physical examination.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Exams, other than those stated above, including insurance, licensing, and employment exams

2) Eye Examinations

The Plan covers one routine eye examination in each 24-month period with an ophthalmologist or optometrist.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network:* Member pays a $15 Tier 1 Copayment per visit.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

b. Sick or Injured Care

The Plan covers care when you are sick, injured or require medical management for a chronic condition. Services include, but are not limited to, necessary care

and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth, diagnosis and treatment, injections, radiation therapy, diagnostic tests and x-rays, dressings, sutures, and casting.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice.

Member Cost:

- *In-Network*: No Member Cost after the applicable Copayment

  Tier 1 Copayment: $15 per office visit.

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

c. Emergency Room Care

In the event of a Medical Emergency, you are covered at the *In-Network* benefit payment level in a Hospital emergency room. Please remember for continued *In-Network* coverage, all follow-up care must be provided by a Participating Provider

Member Cost:

- *In-Network*: Member pays a $50 Copayment per ER visit. This Copayment is waived if you are admitted directly from the emergency room, in which case you will be responsible for the $300 Hospital Inpatient Copayment.

- *Out-of-Network:* Member pays a $50 Copayment per ER visit. This Copayment is waived if you are admitted directly from the emergency room, in which case you will be responsible for the $300 Hospital Inpatient Copayment.

d. Diagnostic Lab and X-Rays

The Plan covers outpatient diagnostic laboratory and x-ray services to diagnose illness, injury, or pregnancy.

The Plan also covers human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Massachusetts Department of Public Health).

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice.

Member Cost:

- *In-Network*: No Member Cost.

- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

e. Physical and Occupational Therapies

Outpatient physical and occupational therapies are each covered up to 90 consecutive days per illness or injury. Services are covered only when needed to improve your ability to perform Activities of Daily Living and when, in the opinion of your Provider, the services are likely to result in significant improvement in your condition within that time period. Your Provider will order therapy for you based on your condition and needs.

Physical and occupational therapies are also covered under your inpatient hospital, home health and hospice benefits. When such therapies are part of an approved home care treatment plan they are not subject to the outpatient benefit of 90 consecutive days noted above. However, services are still subject to the criteria for home health care. (Please see the home health and hospice care benefits further in this section for information on in-home coverage.)

Notification:

- If you are using a Participating Provider, (s)he will arrange the services and provide Notification.

- If you are using a Non-Participating Provider, you are responsible for providing Notification by calling **1-800-708-4414**.

Member Cost:

- *In-Network*: Member pays a $15 Tier 1 Copayment per visit.

- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services

- Sensory integrative praxis tests
- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation

f. Speech, Language and Hearing Services

The Plan covers diagnosis and treatment of speech, hearing and language disorders provided by speech-language pathologists and audiologists to the extent Medically Necessary. If you require speech therapy, your Provider will order therapy for you based on your condition or needs.

Prior Plan Approval:

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services, in Section B.3.g. below
- Services for problems of school performance
- Sensory integrative praxis tests
- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation

g. Early Intervention Services

The Plan covers early intervention services when Medically Necessary. Early intervention coverage is provided both *In-Network* and *Out-of-Network* as described below. Coverage is provided for Members from birth through the Member's third birthday. The Plan covers up to $5,200 per calendar year, with a lifetime maximum of $15,600.

Covered Services include:

- Screening and assessment of the need for services
- Physical, speech, and occupational therapy
- Psychological counseling
- Nursing care

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: Member pays a $15 Tier 1 Copayment per visit.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

h. Surgical Day Care

Surgical Day Care is a surgery or procedure performed in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services. The Plan covers Surgical Day Care, including related services.

Prior Plan Approval or Notification:

- If you are using a Participating Provider, (s)he will arrange the admission and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: **1-800-708-4414**.

Member Cost:

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

i. Second Opinions

There may be times when you want a second opinion. The Plan will cover a second opinion from a licensed physician regarding a proposed treatment or diagnosis.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: Member pays the applicable Copayment.

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

j. Allergy Treatment

The Plan covers allergy testing, antigens and allergy treatments.

For *In-Network* coverage, your care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: There is no Member Cost for office visits when only the administration of an allergy injection is provided. Otherwise, the Member pays the applicable Copayment:

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

4. FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT

a. Family Planning Services

The Plan covers the following family planning services:

- Annual gynecological examination
- Family planning consultation
- Pregnancy testing
- Voluntary sterilization, including tubal ligation.
- Voluntary termination of pregnancy
- Contraceptive monitoring
- Genetic counseling
- Vasectomy

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

Office visits:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

  No Member charge for contraceptive devices or injections provided during an office visit.

- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization

b. Infertility Treatment

Infertility is a medical condition defined as the inability of a presumably healthy individual to conceive or produce conception during a period of one year.

The Plan covers the following infertility treatments:

- Consultation and evaluation
- Laboratory tests
- Artificial insemination (AI), including related sperm procurement and banking

- The Plan also covers up to a total of 5 cycles of advanced reproductive technologies (ART) when Medically Necessary. Advanced reproductive technologies includes in-vitro fertilization including embryo placement (IVF-EP), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection (ICSI), and donor egg procedures, including related egg and inseminated egg procurement, processing and banking

Important Notice: HPHC uses clinical guidelines to evaluate whether the use of ART is Medically Necessary. If you are receiving care for infertility, HPHC recommends that you review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38723.**

Prior Plan Approval:

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

Office visits:

- *In-Network*: Member pays a $15 Copayment per office visit for outpatient care, except as otherwise listed.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization
- Any infertility treatment related to voluntary sterilization or its reversal
- Infertility treatment for Members who are not medically infertile
- Any form of surrogacy

5. MATERNITY CARE

The Plan covers the following maternity care services:

- Outpatient Prenatal exams
- Diagnostic tests
- Diet regulation
- Prenatal genetic testing
- Outpatient Post-partum care
- Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If the inpatient stay is less than 48 hours (or 96 hours in the case of a cesarean delivery) the Plan will cover at least one home visit by a registered nurse or certified nurse midwife.
- Nursery charges for routine services provided to a healthy newborn.

Any maternity care, including delivery, from a Non-Participating Provider will be covered at the *Out-of-Network* benefit level.

Notification:

- If you are using a Participating Provider, (s)he will arrange the admission and provide Notification.
- If you are using a Non-Participating Provider, you are responsible for providing Notification by calling **1-800-708-4414**.

Member Cost:

Office visits:

- *In-Network*: No Member Cost.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- Planned home births

6. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

If you need mental health care or substance abuse services, you must call the Behavioral Health Access Center at **1-888-777-4742**. The phone line is staffed by licensed mental health clinicians. They will assist you in finding appropriate Providers and arranging the services you require. Your Plan covers inpatient, intermediate and outpatient services as described below.

HPHC requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity of mental health services will be made in consultation with licensed mental health clinicians.

Prior Plan Approval:

- For all *In-Network* coverage, you must call the Behavioral Health Access Center. The Behavioral Health Access Center will assist you in determining the type of care you need, finding appropriate Participating Providers, and arranging the services you require. To contact the Behavioral Health Access Center, please call **1-888-777-4742**.
- For all *Out-of-Network* coverage, you must obtain Prior Plan Approval if you are using a Non-Participating Provider. The Prior Approval process is initiated by calling**: 1-888-777-4742**. Further information about Prior Plan Approval may be found in Section A.6. on page 12.

Member Cost and Benefit Reductions:

Deductible:

- *In-network*: None
- *Out-of-Network*: $150 per Member, $300 per Family

The Deductibles for mental health and substance abuse services accumulate separately from medical care.

Out-of-Pocket Maximum:

- *In-Network:* $1,000 per Member, $2,000 per Family
- *Out-of-Network*: $3,000 per Member per calendar year

Please note: *In-Network* Out-of-Pocket Maximums for mental health and substance abuse services include Copayments and exclude prescription drug Copayments and Benefit Reductions. *Out-of-Network* Out-of-Pocket Maximums for mental health and substance abuse services include Deductible and Coinsurance and exclude Copayments, prescription drug Copayments, Benefit Reductions, and any charges in excess of the Reasonable Charge. Separate Out-of-Pocket Maximums exist for mental health and substance abuse services and medical care.

Benefit Reductions:

- *In-Network*: None
- *Out-of-Network*: $200 applied to any service that requires Prior Plan Approval if such Prior Plan Approval is not received.

a. Inpatient Services - Mental Health and Substance Abuse Services

- Inpatient mental health care is covered when it is Medically Necessary.
  - Services are covered in a general or psychiatric Hospital without day limits.
- Inpatient rehabilitative care for substance abuse is covered when it is Medically Necessary.
  - Services are covered in a general Hospital or substance abuse facility without day limits.
- Inpatient detoxification is covered as long as it is Medically Necessary.

If you are readmitted to an In-Network acute care hospital or behavioral health hospital within 30 calendar days of a discharge, your second Inpatient Copayment will be waived. Readmission does not have to be to the same hospital or for the same condition. For example, if you were admitted to a hospital on February 2nd and discharged on February 5th you would pay your Inpatient Copayment. If on February 20th you were readmitted to a hospital, your Inpatient Copayment will be waived. However, if you are readmitted to the hospital on March 7th, you are responsible for paying your Inpatient Copayment. This waiver is limited to a calendar year basis. For example, if you were discharged from a hospital on December 16th, you would pay your Inpatient Copayment. If you are readmitted to a hospital on

January 4th, you would be responsible for your Inpatient Copayment, since it occurs in a new calendar year. **Please note: When you are billed for an Inpatient Copayment that should be waived, you must notify Harvard Pilgrim's Member Services Department so that we may adjust your claims.**

Member Cost

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $200 Hospital Inpatient Copayment per admission, up to a maximum of $800 per calendar year.
- *Out-of-Network*: Member pays a $150 Hospital Inpatient Copayment per admission, after Deductible.

Coinsurance:

- *In-Network*: None
- *Out-of-Network*: Member pays 20% after the Deductible and Hospital Inpatient Copayment, and any balance above the Reasonable Charge.

b. Outpatient Services - Mental Health and Substance Abuse Services

The Plan covers outpatient mental health care and substance abuse services. Coverage is provided for evaluation, diagnosis, treatment and crisis intervention.

Member Cost:

Office Visits

In-Network:

- Individual therapy visits: Member pays a $15 Copayment.
- Group therapy visits: Member pays a $10 Copayment.

Out of network:

- Visits 1-15 (Individual or Group therapy): Member pays 20% after the Deductible, and any balance above the Reasonable Charge.
- Visits 16 and over (Individual or Group therapy): Member pays 50% after the Deductible, and any balance above the Reasonable Charge.

c. Intermediate Mental Health and Substance Abuse Services

The Plan covers intermediate mental health and substance abuse services. Intermediate mental health and substance abuse services are at an acute level of care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization.

Intermediate care services when authorized may include detoxification, acute residential treatment (long-term residential treatment is not covered), crisis stabilization, day/partial hospital programs, structured outpatient programs, 24-hour intermediate care facilities, and therapeutic foster care.

Member Cost:

- *In-Network*: No Member Cost.
- *Out of network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Mental health services that are (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health.

d. Psychopharmacological Services

The Plan covers outpatient detoxification and psychopharmacological services to the extent they are Medically Necessary. The Behavioral Health Access Center will refer you for care, as described previously in this *Benefit Handbook*.

Member Cost:

- *In-Network*: Member pays a $10 Copayment per visit.
- *Out of Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

e. Psychological Testing and Neuropsychological Assessment

The Plan covers psychological testing and neuropsychological assessment to the extent they are Medically Necessary.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: No Member Cost.
- *Out of Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Sensory integrative praxis tests

7. DENTAL SERVICES

The Plan covers only the limited dental services described below.

The benefits described in Sections B.7.a – B.7.d are provided only when the Member has a serious medical condition, including but not limited to, hemophilia or heart disease, that makes it essential that he or she be admitted to a general Hospital as an inpatient or to a Surgical Day Care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely.

a. Extraction of Impacted Teeth

The Plan covers the extraction of one or more bone impacted. Pre-operative and post-operative care, x-rays and anesthesia are covered.

For coverage at the *In-Network* level, care must be provided by a Participating Provider.

For coverage at the *Out-of-Network* level, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures

b. Extraction of Seven or More Teeth

The Plan covers the extraction of seven or more sound natural teeth.

For coverage at the *In-Network* level, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider , you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

c. Removal of Tumors or Cysts

The Plan covers the excision of radicular cysts involving the roots of three or more teeth.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

d. Gingivectomies of Two or More Gum Quadrants

The Plan covers gingivectomies (including osseous surgery) of two or more gum quadrants.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

e. Emergency Dental Care

The Plan covers emergency dental care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within 72 hours of injury.

Only the following services are covered:

- Initial first aid (trauma care)
- Reduction of swelling
- Pain relief
- Covered non-dental surgery
- Non-dental diagnostic x-rays
- Extraction of teeth needed to avoid infection of teeth damaged in the injury
- Suturing and suture removal
- Re-implanting and stabilization of dislodged teeth
- Re-positioning and stabilization of partly dislodged teeth
- Medication received from the Provider

For *In-Network* coverage, all follow-up care must be provided or arranged by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

RELATED EXCLUSIONS:

- Fillings
- Crowns
- Gum care, including gum surgery
- Braces
- Root canals
- Bridges
- Dentures
- Bonding

Member Cost:

Office visits:

- *In-Network*: Member pays a $25 Copayment per visit.
- *Out-of-network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Emergency Room:

- *In-Network*: Member pays a $50 Copayment per ER visit.
- *Out-of-network*: Member pays a $50 Copayment per ER visit.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

f. Oral Surgery Procedures

The Plan covers oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal of benign or malignant tumors, to the same extent as other surgical procedures described in this *Benefit Handbook*.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Prior Plan Approval

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

Office visits:

- *In-Network*: Member pays a $25 Copayment per visit.
- *Out-of-network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Fillings
- Crowns
- Gum care, including gum surgery
- Braces
- Root canals
- Bridges
- Dentures
- Bonding

8. OTHER SERVICES

a. Home Health Care

When you are homebound for medical reasons, the Plan covers the home health care services stated below on a short-term intermittent basis. To be eligible for home health care, your doctor must find that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your doctor expects you will meet in a reasonable period of time. Home health care services must be approved by HPHC.

Care on a "short-term intermittent basis" means care that is provided fewer than eight hours per day, on a less than daily basis, up to 35 hours per week, for up to 21 consecutive days. If you receive more than one type of skilled service at home, these time limits apply to all services combined.

When you qualify for home health care services as stated above, the Plan also covers the following, when Medically Necessary:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Medical social services
- Nutritional counseling
- Services of a home health aide

Durable medical equipment and supplies are also covered to the extent that they are a medically necessary component of the home health care services being provided.

Please note that physical and occupational therapies covered under the home health care benefit are not subject to the outpatient benefit of 90 consecutive days per condition. However, services are still subject to Prior Plan Approval for home health care, as described below.

Prior Plan Approval:

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Home health care extending beyond a short-term intermittent basis, as previously described
- Private duty nursing

b. Hospice Services

The Plan covers hospice services for a terminally ill Member with a life expectancy of 6 months or less who needs the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. (Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to five days every three months, not to exceed 14 days per calendar year. Inpatient care is only covered when Medically Necessary to control pain and manage acute and severe clinical problems which cannot be managed in a home setting.)

Covered services include: physician services; nursing care; social services; counseling services; care to relieve pain; home health aide services; occupational, physical, speech, and respiratory therapy; medical supplies; appliances; drugs which cannot be self-administered; and respite care.

Prior Plan Approval:

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

- *In-Network*: No Member Cost for inpatient or outpatient hospice care. Member pays a $300 Hospital Inpatient Copayment for acute inpatient services.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

c. House Calls

The Plan covers house calls from a licensed physician to the extent they are Medically Necessary.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may use the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per visit

  Tier 2 Copayment: $25 per visit

  Tier 3 Copayment: $35 per visit

- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

d. Durable Medical and Prosthetic Equipment

The Plan covers durable medical equipment including prosthetic devices when Medically Necessary and ordered by your doctor. The cost of the repair and maintenance of covered equipment is also covered.

HPHC will determine whether to rent or buy all equipment. For equipment that is covered In-Network, HPHC may recover the equipment, excluding prosthetic devices, if your Provider determines you no longer need it or your coverage with the plan ends.

Coverage is only available for:

- The least costly equipment or prosthesis, excluding prosthetic arms and legs, adequate to allow you to do Activities of Daily Living;
- Prosthetic arms and legs which are the most appropriate model that adequately meets the Member's medical needs in the performance of Activities of Daily Living; and
- One item of each type of equipment that meets the Member's need. No back-up items or items that serve duplicate purposes are covered. For example, the Plan covers a manual or an electric wheelchair, not both.

In order to be covered, all equipment must be:

- Able to withstand repeated use
- Not generally useful in the absence of disease or injury
- Suitable for home use
- Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part. (This does not apply to prostheses.)

Covered equipment includes:

- Respiratory equipment
- Certain types of braces
- Oxygen and oxygen equipment
- Hospital beds
- Wheelchairs
- Walkers
- Crutches
- Canes
- Insulin pumps and blood glucose monitors, including voice-synthesizers and visual magnifying aids when Medically Necessary for their use

Covered prostheses include:

- Prosthetic arms and legs
- Artificial eyes
- Breast prostheses, including replacements and mastectomy bras
- Ostomy supplies
- Wigs, up to $350 per Member per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury
- Therapeutic molded shoes, and foot orthotics needed to prevent or treat complications of diabetes

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, the Non-Participating Provider of your choice will provide or arrange for the care you need.

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

The following items are not covered:

- Exercise equipment
- Therapeutic molded shoes, and foot orthotics, except for severe diabetic foot disease
- Dentures
- Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft
- Any devices or special equipment needed for sports or occupational purposes
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Any type of thermal therapy device

e. Ambulance Transport

1) Ambulance Transport, Non-Emergency

The Plan covers non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary.

Prior Plan Approval

- If you are using a Participating Provider, (s) he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval for non-emergency ambulance transport by calling **1-800-708-4414.**

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

2) Ambulance Transport, Emergency

In the event of a Medical Emergency, coverage is provided for ambulance transport to the nearest hospital that can render Medically Necessary care to a Member.

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network:* No Member Cost.

f. Reconstructive Surgery and Procedures

For purposes of this *Benefit Handbook*, reconstructive surgery is any procedure to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease.

The Plan covers surgery for post-mastectomy coverage including:

1) reconstruction of the breast on which the mastectomy was performed;
2) surgery and reconstruction of the other breast to produce symmetrical appearance; and
3) prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Prior Plan Approval or Notification:

- If you are using a Participating Provider,(s)he will arrange the services and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: **1-800-708-4414**.
- Please see the list in Sections A.6. and A.7., on pages 12-15, for details regarding which services require Prior Plan Approval and Notification.

Member Cost:

Office visits:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

g. Kidney Dialysis

The Plan covers kidney dialysis on an inpatient or outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will pay only for services whose payments would exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, drugs and equipment necessary for dialysis. Installation of home equipment is covered up to $300 in a Member's lifetime.

Prior Plan Approval

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval for inpatient services or services provided in the home by calling **1-800-708-4414**.

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network:* Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

h. Human Organ Transplants

The Plan covers Medically Necessary human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer.

The Plan covers the following services when the recipient is a Member of the Plan:

- Care for the recipient
- Donor search costs through established organ donor registries
- Donor costs that are not covered by the donor's health plan

If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.

Prior Plan Approval or Notification:

- If you are using a Participating Provider, (s)he will arrange the services you need and provide Notification or obtain Prior Plan Approval, whichever is appropriate.
- If you are using a Non-Participating Provider, you are responsible for providing Notification or obtaining Prior Plan Approval, whichever is appropriate, by calling: **1-800-708-4414**.
- Please see the list in Sections A.6. and A.7., pages 12-15, for details regarding which services require Prior Plan Approval or Notification.

Member Cost:

Office visits:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment per admission.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Human organ or bone marrow transplants that are Experimental or Unproven

i. Special Infant Formulas and Low Protein Foods

The Plan covers the following:

- Special infant formulas, including those formulas approved by the Massachusetts Department of Public Health
- Formulas for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophogeal reflux, gastrointestinal motility, or chronic intestinal pseudo-obstruction
- Low protein foods for inherited diseases of amino and organic acids up to $2,500 per Member per calendar year.

Prior Plan Approval:

- If you are using a Participating Provider, (s)he will provide or arrange for the care you need.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling: **1-800-708-4414**.

Member Cost:

- *In-Network*: No Member charge.
- *Out-of-Network:* The Plan pays 80% of the Reasonable Charge after the Deductible, then Member pays 20% and any balance above the Reasonable Charge.

j. Diabetes Treatment

The Plan covers the following services for persons with diabetes to the extent Medically Necessary:

a. Therapeutic molded shoes and inserts for severe diabetic foot disease prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; dosage gauges; injectors; lancet devices; voice synthesizers; and visual magnifying aids.

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

b. Blood glucose monitors, insulin pumps and supplies and infusion devices

Member Cost:

- *In-Network*: No Member Cost.
- *Out-of-Network*: No Member Cost.

c. Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips.

Member Cost:

- Please see the Prescription Drug Brochure included in this booklet. Your prescription drug Copayments are also listed on your ID Card.

k. Cardiac Rehabilitation

The Plan covers Medically Necessary cardiac rehabilitation services for Members with established coronary artery disease or unusual and serious risk factors for such disease.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

The Plan also covers approved Coronary Artery Disease (CAD) programs for all Plan Members. These programs are designed to help Members who meet the program's defined criteria for CAD by supporting them in making lifestyle changes that can reduce cardiac risk factors. This benefit is available to Members with a history of heart disease.

Member Cost:

- *In-Network*: Member pays 10% Coinsurance
- *Out-of-Network*: Not Covered

l. Temporomandibular Joint Dysfunction (TMD) Services

Your coverage for TMD services is limited to medical services only. The Plan covers only the following services:

- Initial consultation

- X-rays
- Physical therapy, subject to the visit limit for outpatient physical therapy
- Surgery

Prior Plan Approval:

- If you are using a Participating Provider, (s)he will arrange the services and obtain Prior Plan Approval.
- If you are using a Non-Participating Provider, you are responsible for obtaining Prior Plan Approval by calling **1-800-708-4414**.

Member Cost:

Office visits:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Surgical Day Care Services:

- *In-Network*: Member pays a $100 Surgical Day Care Copayment per admission.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

Hospital Inpatient Copayment:

- *In-Network*: Member pays a $300 Hospital Inpatient Copayment.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- All services of a dentist for Temporomandibular Joint Dysfunction (TMD), except oral surgery

m. Prescription Drug Coverage

Please see the *Prescription Drug Brochure* included in this booklet. Your prescription drug Copayments are also listed on your ID Card.

n. Chiropractic Care

The Plan covers care by a chiropractor up to a maximum of 20 visits per Member per calendar year for the treatment of orthopedic and neuromuscular conditions. The following services are covered:

- Initial diagnostic x-ray
- Care within the scope of standard chiropractic practice

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: Member pays a $15 Copayment per visit.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

RELATED EXCLUSIONS:

- Care outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease, or treatment with crystals
- Diagnostic testing other than an initial x-ray

o. Vision Hardware for Special Conditions

The Plan provides limited coverage for contact lenses or eyeglasses needed for certain eye conditions. The coverage and Member Cost provided for these conditions is as follows:

1. Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase and fitting of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is covered in full.
2. Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered in full per year. Coverage of up to $50 per year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per calendar year.

3. Keratoconus. One pair of contact lenses is covered in full per year if there is a medical need. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per calendar year.

4. Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers the full cost of a pair of eyeglass lenses and up to $50 toward the purchase of the frame, or the full cost of a pair of contact lenses.

Member Cost:

- *In-Network*: No Member Cost up to the benefit limits described above.
- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge, up to the applicable benefit limits described above.

p. Hearing Aid Coverage

The Plan covers hearing aids up to a maximum of $1,700 in a two calendar year period at 100% for the first $500 and 80% for the next $1,500 per Member.

q. Drugs That Cannot be Self-Administered

The Plan covers drugs that cannot be self-administered, including hormone replacement therapy (HRT), Coverage includes drugs that cannot be self-administered that have been approved by the United States Food and Drug Administration, except drugs that the Plan excludes or limits.

Member Cost:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

r. Clinical Trials for the Treatment of Cancer

The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer under the terms and conditions provided for under Massachusetts insurance law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor, or provider.

For *In-Network* coverage, care must be provided by a Participating Provider.

For *Out-of-Network* coverage, you may go to the Non-Participating Provider of your choice for the care you need.

Member Cost:

- *In-Network*: Member pays the applicable Copayment

  Tier 1 Copayment: $15 per office visit

  Tier 2 Copayment: $25 per office visit

  Tier 3 Copayment: $35 per office visit

- *Out-of-Network*: Member pays 20% after the Deductible, and any balance above the Reasonable Charge.

s. Hypodermic Syringes and Needles

The plan covers hypodermic syringes and needles to the extent Medically Necessary.

You must get a prescription from your physician and present it at any pharmacy for coverage. For In-Network coverage you must use a Plan participating pharmacy. A list of Plan participating pharmacies is available from the Member Services Department or at www.harvardpilgrim.org

Member Cost:

- *Retail Pharmacy:* Member pays the following Copayments for up to a 30-day supply:

  Tier 1 Copayment: $10

  Tier 2 Copayment: $20

Tier 3 Copayment: $40

- *Mail Order Pharmacy:* Member pays the following Copayments for a 90-day supply:

  Tier 1 Copayment: $20

  Tier 2 Copayment: $40

  Tier 3 Copayment: $90

9. EXCLUSIONS

The Plan does not cover any of the following:

- A provider's charge to file a claim or to transcribe or copy your medical records
- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting
- Acupuncture, aromatherapy, and alternative medicine
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Any form of surrogacy
- Any services not specified in this *Benefit Handbook* and your *Schedule of Benefits*
- Any service or supply furnished along with a non-covered service
- Blood and blood products
- Care by a chiropractor that falls outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease, treatment with crystals, or diagnostic testing for chiropractic care other than an initial x-ray
- Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this *Benefit Handbook*
- Charges for missed appointments
- Charges for services received after the date on which your membership ends
- Commercial diet plans, weight loss programs, and any services in connection with such plans or programs
- Cosmetic procedures, including those for mental health reasons, except as described in your Benefit Handbook for post-mastectomy or reconstructive surgery
- Costs for services covered by workers' compensation, third party liability, other insurance coverage or an employer under state or federal law
- Dental services, except the specific dental services listed in this *Benefit Handbook*. Dental services for temporomandibular joint dysfunction (TMD), as well as restorative, periodontal, orthodontic, endodontic, prosthodontic services are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic or periodontal procedures and dental fillings; crowns; gum care, including gum surgery; braces; root canals; bridges; and bonding are not covered
- Dentures
- Devices or special equipment needed for sports or occupational purposes
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Any products or services, including, but not limited to drugs, devices, treatments, procedures, and diagnostic tests, which are Experimental, Unproven, or Investigational
- Educational services and testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities
- Electrolysis, routine foot care services, biofeedback, hypnotherapy, psychoanalysis, pain management programs, massage therapy (including myotherapy), sports medicine clinics, services by a personal trainer, cognitive rehabilitation programs, and cognitive retraining programs
- Eyeglasses, contact lenses and fittings, except as listed in your *Schedule of Benefits* as well as this *Benefit Handbook*
- Gender reassignment surgery, including related drugs or procedures
- Any services or supplies furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies except for the following:

(a) a benefit plan established for its civilian employees, (b) Medicare (Title XVIII of the Social Security Act), (c) Medicaid (any state medical assistance program under Title XIX of the Social Security Act), or (d) a program of hospice care.

- Group diabetes training or educational programs or camps
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs
- Hospital charges with dates of service after your hospital discharge
- Infertility treatment for Members who are not medically infertile
- Mental health services that are (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Personal comfort or convenience items (including telephone and television charges); non-durable medical supplies, unless used in the course of diagnosis or treatment in a medical facility or in the course of authorized home health care; exercise equipment; and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft
- Physical examinations or services for insurance, licensing or employment purposes which are not otherwise Medically Necessary
- Planned home births
- Preventive dental care
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Rest or Custodial Care
- Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal) and the costs of achieving pregnancy through surrogacy
- Sclerotherapy for the treatment of spider veins
- Sensory integrative praxis tests
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn for up to 30 days after the newborn's birth
- Services for cosmetic purposes, except as described in this *Benefit Handbook* for post-mastectomy services or reconstructive surgery
- Services for non-Members and services after membership termination
- Services for which no charge would be made in the absence of insurance
- Services for which you are legally entitled to treatment at government expense. This includes services for disabilities related to military service
- Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption or (2) anyone who ordinarily lives with you
- Services that are not Medically Necessary
- Taxes or assessments on services or supplies
- Any type of thermal therapy device
- Therapeutic molded shoes, and foot orthotics, except for the treatment of severe diabetic foot disease
- Transportation other than by ambulance
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
- Unless otherwise specified in the *Schedule of Benefits* or *Benefit Handbook*, the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription

SECTION C. STUDENT DEPENDENT COVERAGE

When your eligible Dependent child goes to school away from home, he or she is still covered by the Plan. The Plan coverage works one of two ways for student Dependents, depending on where they get care while they go to school.

1. STUDENTS INSIDE THE ENROLLMENT AREA

If your Dependent child receives covered services inside the Enrollment Area, he or she can obtain benefits at the *In-Network* level by receiving care from Participating Providers.

The Enrollment Area is a list of cities and towns where Participating Providers are available to manage your care. You may obtain the list of the cities and towns of the current Enrollment Area from HPHC's Member Services Department. HPHC may revise the Enrollment Area from time to time.

2. STUDENTS OUTSIDE THE ENROLLMENT AREA

If your child goes to school and receives covered services outside the Enrollment Area, the Plan provides coverage at the *Out-of-Network* level.

Your child may also receive Covered Services outside of the Enrollment Area with lower Member Cost than Out-of-Network coverage, as described in Section A.5, from our national network of affiliated providers.

All the rules and limits on coverage listed in the *Benefit Handbook* for *Out-of-Network* coverage apply to these benefits.

SECTION D. REIMBURSEMENT AND CLAIMS PROCEDURES

The information in this section applies when you receive Covered Services from a Non-Participating Provider. In most cases, you should not receive bills from a Participating Provider for Covered Services.

1. CLAIM FILING PROCEDURES

In order to be paid by the Plan, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.) Claims must be submitted to the following addresses:

Claims for Pharmacy Services

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Claims for Mental Health and Substance Abuse Services:

HPHC - Behavioral Health Access Center
P.O. Box 31053
Laguna Hills, CA 92654

All Other Claims:

HPHC Claims
P.O. Box 699183
Quincy, MA 02269-9183

2. BILLING BY PROVIDERS

If you get a bill for a Covered Service you may ask the Provider to:

1) Bill us on standard health care claim forms (such as the CMS 1500 or the UB-82/92 form); and

2) Send it to us at the address listed on the back of your Plan ID card.

3. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a Provider for a Covered Benefit, send receipts from the Provider showing proof of payment.

Here is the information we need to process your claim:

1) The Subscriber's name, address and Plan ID number

2) The patient's full name

3) The patient's date of birth

4) The patient's Plan ID number on the front of the patient's Plan ID card

5) The date the service was rendered

6) A brief description of the illness or injury

7) For pharmacy items, a drug receipt stating: the Member's name and Plan ID number, the name of the drug or medical supply, the drug NDC number, the quantity, the number of days' supply, the date the prescription is filled, the prescribing physician's name, the pharmacy name and address, and the amount paid

Members may contact the MedImpact help desk at **1-800-788-2949** for assistance with pharmacy claims.

Please note that we may need more information for some claims. If you have any questions about claims, please call our Member Services Department at **1-888-333-4742**.

4. LIMITS ON CLAIMS

To be eligible for payment, the Plan must get claims within two years of the date care was received. We limit the amount we will pay for services that are rendered by Non-Participating Providers. The most we will pay for such services is the Reasonable Charge. You will be responsible for the balance if the claim is for more than the Reasonable Charge.

SECTION E. APPEALS AND COMPLAINTS

This section explains HPHC's procedures for processing appeals and complaints and the options available to you if an appeal is denied.

1. BEFORE YOU FILE AN APPEAL

Claim denials may result from a misunderstanding with a Provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact an HPHC Member Service Representative prior to filing an appeal. (A Member Service Representative can be reached toll free at **1-888-333-4742** or at **1-800-637-8257** for TTY service.) The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

2. MEMBER APPEAL PROCEDURES

Any Member who is dissatisfied with a HPHC service coverage decision may appeal to HPHC. Appeals may also be filed by a Member's representative or a Provider acting on a Member's behalf. HPHC has established the following steps to ensure that Members receive a timely and fair review of internal appeals.

HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance, please call **1-888-333-4742.**

a. Initiating Your Appeal

To initiate your appeal, you or your representative should write or FAX a letter to us about the coverage you are requesting and why you feel it should be granted. (If your appeal qualifies as an expedited appeal, you may contact us by telephone. See Section E.2.c. on page 41 for the expedited appeal process) Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills. We must receive this information within one hundred and eighty (180) days of HPHC's denial of coverage.

If you have a representative, including a medical Provider, submit an appeal on your behalf, the appeal must include a statement, signed by you, authorizing the representative to act on your behalf. In the case of an expedited appeal, such authorization must be provided within 48 hours after submission of the appeal.

For all appeals, except mental health and substance abuse services appeals, please send your request to the following address:

HPHC Member Appeals
Member Services Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169.

Telephone: 1-888-333-4742
FAX: 1-617-509-3085

If your appeal involves a mental health or substance abuse service, please send it to the following address:

HPHC Behavioral Health Access Center
P.O. Box 850346
Braintree, MA 02185

Telephone: 1-888-777-4742
FAX: 1-800-383-2194

No appeal shall be deemed received until actual receipt by HPHC at the appropriate address or telephone number listed above.

When we receive your appeal, we will assign an Appeal Coordinator to manage your appeal throughout the appeal process. We will send you a letter identifying your Appeal Coordinator. That letter will include detailed information about the appeal process. Your Appeal Coordinator is available to answer any questions you may have about your appeal. Please feel free to contact your Appeal Coordinator if you have any questions or concerns about the appeal process.

b. Appeal Process

The Appeal Coordinator will investigate your appeal and determine if additional information is required. Such information may include medical records, statements from your doctors, and bills and receipts for services you have received. You may also provide HPHC with any written comments, documents, records or other information related to your claim.

HPHC divides appeals into two types, "Pre-Service Appeals" and "Post- Service Appeals" as follows:

- A "Pre-Service Appeal" requests coverage of a health care service that the Member has not yet received.
- A "Post-Service Appeal" requests coverage of a health care service that the Member has already received.

HPHC will review Pre-Service Appeals and send a written decision within 30 days of the date the appeal was received by HPHC. HPHC will review Post-Service Appeals and send a written decision within 60 days of the date the appeal was received by HPHC. These time limits may be extended by mutual agreement between you and HPHC.

After we receive all the information needed to make a decision, your Appeal Coordinator will inform you, in writing, whether your appeal is approved or denied. HPHC's decision of your appeal will include: (1) a summary of the facts and issues in the appeal; (2) a summary of the documentation relied upon; (3) the specific reasons for the decision, including the clinical rational, if any; and (4) the identification of any medical or vocational expert consulted in reviewing your appeal. This decision is HPHC's final decision under the appeal process. If HPHC's decision is not fully in your favor, the decision will also include a description of other options, if any, for further review of your appeal. These are also described in Section 3, below.

If your appeal involves a decision on a medical issue, the Appeal Coordinator will obtain the opinion of a qualified physician or other appropriate medical specialist. The health care professional conducting the review must not have either participated in any prior decision concerning the appeal or be the subordinate of such person. Upon request, your Appeal Coordinator will provide you with a copy, free of charge, of any written clinical criteria used to decide your appeal and the identity of the physician (or other medical specialist) consulted concerning the decision.

You have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and your appeal.

c. Expedited Review Procedure

HPHC will provide you with an expedited review if your appeal involves services which:

(1) If delayed, could seriously jeopardize your life or health or ability to regain maximum function,

(2) In the opinion of a physician with knowledge of your medical condition, would result in severe pain that cannot be adequately managed without the care or treatment, or

(3) Involves the continuation of inpatient services following emergency care.

If your appeal involves services that meet one of these criteria, please inform us and we will provide you with an expedited review.

You, your representative or a Provider acting on your behalf may request an expedited appeal by telephone or fax. (Please see "Initiating Your Appeal," above, for the telephone and fax numbers.) HPHC will investigate and respond to your request within 72 hours. We will notify you of the decision on your appeal by telephone and send you a written decision within two business days thereafter.

If you request an expedited appeal of a decision to discharge you from a Hospital, we will continue to pay for your hospitalization until we notify you of our decision.

To enable us to conduct such a quick review of the expedited appeal, we must limit the expedited appeal process to the circumstances listed above. Your help in promptly providing all necessary information is essential for us to provide you with this quick review. If we do not have sufficient information necessary to decide your appeal, HPHC will notify you that additional information is required within 24 hours after receipt of your appeal.

3. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with HPHC's decision on your appeal, you may have your appeal decision reviewed by the Group Insurance Commission if it involves the Plan's benefit coverage decision about a covered service.

Appeals must be directed in writing to:

Executive Director
Group Insurance Commission
PO Box 8747
Boston, MA 02114-8747

4. FORMAL COMPLAINT PROCESS

You may file a complaint when you seek redress of any aspect of HPHC's service, other than a denial of coverage (issues concerning a denial of coverage are handled under the appeals process).

For all complaints, except mental health and drug and alcohol rehabilitation complaints, please call or write to:

HPHC Member Services Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169

Telephone: 1-888-333-4742

For a complaint involving mental health and drug and alcohol rehabilitation services, please call or write to:

Behavioral Health Access Center
P.O. Box 850346
Braintree, MA 02185

Telephone: **1-888-777-4742**
FAX: **1-800-383-2194**

We will respond to you as quickly as we can. Most complaints can be investigated and responded to within thirty (30) days.

SECTION F. ELIGIBILITY

This section describes requirements concerning eligibility under the Plan. The eligibility of Members and Dependents and effective dates of coverage are determined by the GIC.

1. MEMBER ELIGIBILITY

Eligible employees and retirees of the Commonwealth Municipalities and other entities may join this Plan as Subscribers. Coverage will begin on the first day of the month following the earlier of 1) 60 days of employment, or 2) two calendar months. If you fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible Dependents, if any, at a later date. In general, employees who choose not to join a health plan when first eligible must wait until the next annual enrollment period to join. This will apply to you if you:

- Fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible Dependents, if any, at a later date
- Declined this coverage when you were first eligible because you or your eligible Dependent was covered under another group health plan or other health insurance coverage at the time of open enrollment, and you or your eligible dependent has subsequently lost such other coverage; or
- Declined this coverage when you were first eligible, and you have acquired a Dependent through marriage, birth, adoption, or placement for adoption.

Eligible employees and their eligible Dependents may enroll for this off-cycle coverage within 31 days after any of the following events:

- Your coverage under the other health plan ends
- Your marriage or divorce
- The birth, adoption, or placement for adoption of your Dependent child

HPHC will issue identification cards for each enrolled Member within two weeks of receipt of enrollment information from the GIC. The identification card should be presented whenever a Member receives Covered Services.

a. Residence Requirement

To be eligible for coverage under this Plan, all Members must live and maintain a permanent residence within the HPHC Enrollment Area at least nine months of a year.

This does not apply to a Dependent child who is Enrolled as a full-time student.

If you have any questions about this requirement, you may call the Member Services Department for a current list of the cities and towns in the Enrollment Area.

b. Who is Covered

Individual Coverage covers the Subscriber only (except for routine nursery care services if the mother only has Individual Coverage and the newborn is not being added to the policy). Family Coverage covers the Subscriber and the following enrolled Dependents:

- The Subscriber's legal spouse
- The child(ren) of the Subscriber (or spouse of the Subscriber) until the earlier of:
  - The end of the month following the child's 26th birthday or
  - Two calendar years after the child is no longer claimed as a federal tax dependent under the Internal Revenue Code by the Subscriber or the Subscriber's spouse
- The child(ren) of an eligible Dependent of the Subscriber until the earlier of:
  - The end of the month following the child's 26th birthday or
  - Two calendar years after the child is no longer claimed as a federal tax dependent under the Internal Revenue Code by the Subscriber or the Subscriber's spouse
- Certain Dependent children with disabilities
- And, in some cases, a divorced spouse.

Parents of children age 19 to 26 years of age are required to complete the GIC Dependent Age 19 and Over Application for coverage.

Special provisions may be made for coverage of Dependent children with disabilities age 19 and over.

Under the federal law known as COBRA, coverage may also be extended at up to 102% of the premium (no premium contribution by the Commonwealth) for up to 36 months as noted in the section on Termination, which follows.

c. Divorced Spouses

Spouses who are divorced from employees who are enrolled in this Plan are eligible to continue group coverage unless such coverage is precluded by the divorce agreement. This coverage continues until either the former spouse or employee remarries. After remarriage of the employee, the former spouse may be eligible for continued coverage upon the payment of an additional premium, if the GIC determines that the divorce agreement allows it. Terminated former spouses are eligible for other coverage:

1. Federal law

The federal law known as COBRA provides eligibility for divorced spouses for a maximum of 36 months of continued group coverage from the date coverage is lost at full cost (no contribution from the Commonwealth).

2. Non-Group Coverage Within the Enrollment Area

A divorced spouse who is no longer eligible for the continuation coverage described above may be eligible to enroll in non-group coverage. This non-group coverage varies from group coverage both in cost and the level of benefits. To avoid any waiting periods or pre-existing condition limitations, you are encouraged to apply for non-group coverage within 63 days of termination of your group coverage. To be eligible you must satisfy applicable state law requirements. Under the Massachusetts Health Care Reform Act, Massachusetts residents may enroll, on a direct pay basis, in any small group Buy Direct health plan offered by HPHC.

d. Dependent Children with Disabilities

Physically or mentally disabled children age 19 and older who are incapable of self-support as of their 19th birthday may obtain Handicapped Dependent Coverage. Application must be made to the GIC to obtain this coverage. Coverage is subject to GIC approval and the insured parent's continued coverage with the GIC. If approved, disabled children receive their own identification numbers but are part of the Family. Their coverage ends when the subscriber's coverage ends.

To be eligible, the Handicapped Dependent must be approved for coverage by the GIC.

Coverage is also available for an unmarried child who is permanently and totally disabled and became so by age 19.

e. Retired Employees

Retirees, except for participants in the GIC's Retired Municipal Teacher and Elderly Governmental Retiree Program, are eligible to participate in the Plan if they are not eligible for Medicare. Participants in the GIC's Retired Municipal Teachers and Elderly Governmental Retirees programs are not eligible to enroll in this Plan.

All retirees eligible for, or enrolled in, Medicare Parts A and B must join a separate GIC plan that covers Medicare-eligible retirees. To determine eligibility for Medicare, you should contact your local Social Security Administration office.

f. Changes in Status

It is the responsibility of the Subscriber to inform the GIC of all changes that affect Member eligibility, including but not limited to, divorce, remarriage of either spouse, marriage of a Dependent, Medicare eligibility as a result of disability, death, address changes, when a Dependent previously eligible as a student is no longer enrolled in an accredited school on a full-time basis, and changes in the IRS dependent status of Dependent age 19 and over. Members must inform the GIC of these changes by contacting the GIC. For information on enrolling newly born or adopted children, please see Section F.1.h. on page 45.

g. Dependent Eligibility

To be eligible as a Dependent under this Plan, a Dependent must be:

1. The Subscriber's spouse or surviving spouse (until remarriage); or a divorced spouse who is eligible for Dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended; or

2. A child of the Subscriber or the Subscriber's Dependent (spouse or child), by birth, legal adoption (including a child for whom legal adoption proceedings have been initiated), under custody pursuant to a court order, or under legal guardianship, until the earlier of age twenty-six (26) years, or two years following loss of tax dependency under the Internal Revenue Code; or

3. A child who depends upon the Subscriber or surviving spouse for support, lives with such Subscriber or surviving spouse, and where there is evidence of a regular parent-child relationship satisfactory to the GIC, until the earlier of age of twenty-six (26) years, or two years following loss of federal tax dependency under the Internal Revenue Code; or

4. An orphaned child under the age of twenty-six (26) who is the surviving Dependent of a deceased Subscriber and spouse, or of a surviving spouse, until the age of twenty-six (26) years or until he/she is eligible for other group health coverage, whichever is earlier; or

5. An unmarried child who, upon becoming nineteen (19) years of age, is mentally or physically incapable of earning his/her own living, proof of which must be acceptable to the GIC; or

6. An unmarried child who is permanently and totally disabled and became so before age 19; or

7. A newborn child of the Subscriber's or surviving spouse's Dependent son or daughter until the earlier to occur of; a.) the date the parent of such child ceases to be a Dependent of the covered Subscriber or surviving spouse; or b.) the date the child ceases to be a Dependent.

h. Adding or Removing a Dependent

Members must notify the GIC of any change in the status of a Dependent. Contact the GIC for information on Dependent eligibility and effective dates of coverage. To add a newborn child or adopted child to your GIC coverage, you must contact the GIC.

Benefits under this Plan end if:

- The contract between the GIC and HPHC is cancelled.
- The Subscriber fails to pay the applicable Member cost.
- The Subscriber is no longer a member of the employer's eligible group (for example, if he or she leaves state employment). If an employee leaves the job, but maintains residence within the HPHC Enrollment Area, he or she will be given an opportunity to continue health plan coverage on a non-group (direct pay) basis, when eligible under the law of the employee's state of residence and when HPHC or its affiliated health plans offer non-group coverage in that state.

You also may be eligible for continuation coverage under the federal law known as COBRA. If eligible, federal law permits the employee to extend his or her group coverage for up to 18 months at 102% of premium to the employee with no premium contribution from the employer. Following this 18 month extension, the employee may convert to non-group coverage when eligible under the law of the employee's state of residence if the Plan offers non-group coverage in that state. ***Please refer to Appendix A at the back of this Benefit Handbook for further information regarding COBRA coverage.***

A Member's coverage may also end for any of the following causes:

- Providing false or misleading information on an application for membership.
- The failure to pay required Member Cost.
- The failure to provide requested eligibility information to the GIC.
- Committing or attempting to commit fraud or obtain benefits for which the Member is ineligible under this *Benefit Handbook*.
- Obtaining or attempting to obtain benefits under this *Benefit Handbook* for a person who is not a Member.
- Committing acts of physical or verbal abuse by a Member which pose a threat to Participating Providers or other Members and which are unrelated to the Member's physical or mental condition.

Dependent coverage under this Plan will cease:

On the last day of the month when a Family member no longer qualifies as a Dependent under the rules and regulations of the GIC (e.g., the earlier of either the attainment of age 26, or two years following loss of tax dependency under the Internal Revenue Code). In addition to COBRA coverage, your Dependent may be eligible to continue health plan coverage on a non-group (direct pay) basis if he or she resides in the HPHC Enrollment Area and if he or she is eligible under the law of his or her state of residence. The Dependent should apply for subsequent non-group coverage within 63 days of termination of this Plan in order to avoid waiting periods or pre-existing condition limitations. Evidence of good health is not required for non-group conversion coverage. The benefits of the non-group plan are different from those under this Plan. Additionally, under the requirements of the Massachusetts Health Care Reform Act, Massachusetts residents may enroll, on a direct plan basis, in any Buy Direct health plan offered by HPHC.

1. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this *Benefit Handbook* will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, home owners insurance, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all HMO and other prepaid health plans, Medical or Hospital Service Corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day. Members who are eligible for Medicare as a result of disability or end stage renal disease must notify the GIC.

Coordination of benefits will be based upon the Reasonable Charge for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans.

When a Member is covered by two or more Health Benefit Plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined before those of secondary plan(s) and without considering the benefits of secondary plan(s). The benefits of secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules shall decide which Health Benefit Plans are primary or secondary:

a. Dependent/Non-Dependent

The benefits of the Plan that covers the person as an employee, Member or Subscriber are determined before those of the plan that covers the person as a Dependent.

b. A Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but,

2) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time;

3) However, if the other plan does not have the rule described in (1) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in this Plan (the "birthday rule") will determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

Unless a court order, of which HPHC has knowledge, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

1) First the plan of the parent with custody of the child;

2) Then, the plan of the spouse of the parent with custody of the child; and

3) Finally, the plan of the parent not having custody of the child.

d. Active/Inactive Employee

The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.

e. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, Member or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

If a Member is covered by a Health Benefit Plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.

2. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

When a Member's Plan coverage is secondary to a Member's coverage under another Health Benefit Plan, payment to a provider of services may be suspended until the Provider has properly submitted a claim to the primary plan and the claim has been paid, in whole or in part, or denied by the primary plan. The Plan may recover any payments made for services in excess of the GIC's liability as the secondary plan, either before or after payment by the primary plan.

3. WORKERS' COMPENSATION/ GOVERNMENT PROGRAMS

If the Plan has information indicating that services provided to a Member are covered under Workers' Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, payment may be suspended for such services until a determination is made whether payment will be made by such program. If payment is made for services for an illness or injury covered under Workers' Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, the GIC will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

4. SUBROGATION

Subrogation is a means by which health plans recover expenses for benefits provided where a third party is legally responsible for a Member's injury or illness.

If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury which have been paid for or provided by the Plan, the Plan will be subrogated and succeed to all rights of the Member to recover against such person or entity 100% of the value of the services paid for or provided by the GIC. The GIC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his or her liability carrier or the Member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The GIC will also be entitled to recover from a Member 100% of the value of services provided or paid for by the GIC when a Member has been, or could be, reimbursed for the cost of care by another party.

The GIC's right to recover 100% of the value of services paid for or provided by HPHC is not subject to reduction for a pro rata share of any attorney's fees incurred by the Member in seeking recovery from other persons or organizations. The GIC's right to 100% recovery shall apply even if the recovery the Member receives for the illness or injury is designated or described as being for damages other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

To enforce its subrogation rights under this *Benefit Handbook*, the GIC will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by the GIC for which such party is, or may be, liable.

Nothing in this *Benefit Handbook* shall be construed to limit GIC's right to utilize any remedy provided by law to enforce its rights to subrogation under this *Benefit Handbook*.

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5. MEDICAL PAYMENT POLICIES

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, such coverage shall become primary to the coverage under this *Benefit Handbook* for services rendered in connection with a covered loss under that policy. The benefits under this *Benefit Handbook* shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this *Benefit Handbook* to Members that are covered under any medical payment policy or benefit are payable to the GIC.

6. MEMBER COOPERATION

The Member agrees to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits under this *Benefit Handbook*. Such cooperation will include, but not be limited to, a) the provision of all information and documents requested by the Plan; b) the execution of any instruments deemed necessary by the Plan to protect its rights; c) the prompt assignment to the Plan of any moneys received for services provided or paid for by the Plan; and d) the prompt notification to the Plan of any instances that may give rise to the Plan's rights. The Member further agrees to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

Failure of the Member to perform the obligations stated in this Subsection shall render the Member liable to the Plan for any expenses the Plan may incur, including reasonable attorney's fees, in enforcing its rights under this *Benefit Handbook*.

7. THE PLAN'S RIGHTS

Nothing in this *Benefit Handbook* shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits under this agreement.

8. MEMBERS ELIGIBLE FOR MEDICARE

A Member who is eligible for Medicare, and for whom Medicare is permitted by federal law to be the primary payer, must be covered by both Parts A & B of Medicare and must assign benefits under both Parts to the Plan.

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payer for Covered Services during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payer. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare.

When the Plan provides benefits to a Member for which the Member is eligible under Medicare, the Plan shall be entitled to reimbursement from Medicare for such services. The Member shall take such action as is required to assure this reimbursement.

This section has information about how the Plan is administered.

1. COVERAGE WHEN MEMBERSHIP BEGINS WHILE HOSPITALIZED

a. General Coverage Rules

There are times when Plan membership begins when the Member is already hospitalized. Such hospitalization is covered from the time membership is effective.

b. Newborn Coverage

When a newborn child is a Member, but either the mother is not a Member or a Participating Provider did not perform the delivery, services are covered at the *In-Network* level only if:

- The child is born at a Participating Hospital; and
- HPHC is called within 48 hours of delivery to arrange for a HPHC physician to manage the baby's care.

Please note that the newborn remains eligible for *Out-of-Network* coverage for services like every other Dependent.

2. MISSED APPOINTMENTS

Providers may charge you for appointments you miss if you do not cancel before the scheduled appointment. You can call the Provider to find out how much advance notice is needed to cancel an appointment. The Plan is not responsible for charges for missed appointments and does not count missed appointments toward any benefit limits.

3. LIMITATION ON LEGAL ACTIONS

Any legal action against the Plan, for failing to provide Covered Services, must be brought within 2 years of the denial of any benefit. This does not apply to actions for medical malpractice.

4. LIMIT ON MEMBER COST

Members are required to share the cost of benefits under the Plan. Such Member Cost is limited as indicated below:

a. Medical

1) ***In-Network*:**

- **Hospital Inpatient Copayment:** $300 per admission – up to a maximum of $1,200 per Member per calendar year.
- **Surgical Day Care Services Copayment:** $100 per admission – up to a maximum of $400 per Member per calendar year.

2) ***Out-of-Network*:**

- **Deductible:** $150 per Member, $300 per Family per calendar year
- **Out-of-Pocket Maximum:** $3,000 per Member per calendar year

b. Mental Health and Substance Abuse

1) ***In-Network*:**

- **Hospital Inpatient Copayment**: $200 per admission – up to a maximum of $800 per Member per calendar year.
- **Out-of-Pocket Maximum**: $1,000 per Member per calendar year, $2,000 per Family per calendar year

2) ***Out-of-Network*:**

- **Hospital Inpatient Copayment:** $150 per admission
- **Deductible:** $150 per Member, $300 per Family per calendar year
- **Out-of-Pocket Maximum:** $3,000 per Member per calendar year

Please note:
The Hospital Inpatient Copayments and Surgical Day Care Copayments for medical care accumulate only towards the medical Out-of-Network Out-of-Pocket Maximum. The Hospital Inpatient Copayments for mental health and substance abuse services accumulate only towards the mental health and substance abuse services Out-of-Pocket Maximum.

Deductibles for medical care accumulate separately from the Deductibles for mental health and substance abuse services.

Out-of-Network Out-of-Pocket Maximums include Deductible and Coinsurance (except for Coinsurance for skilled nursing facility care) and exclude Copayments, prescription drug Copayments, Benefit Reductions, and any charges in excess of the Reasonable Charge.

Separate Out-of-Pocket Maximums exist for medical care and mental health and substance abuse services.

If you are readmitted to an In-Network acute care hospital or behavioral health hospital within 30 calendar days of a discharge, your second Inpatient Copayment will be waived. Readmission does not have to be to the same hospital or for the same condition.

5. ACCESS TO INFORMATION

Information from a Member's medical record and information about a Member's physician-patient and hospital-patient relationships will be kept confidential and will not be disclosed without the Member's consent, except for:

a. Use in connection with the delivery of care under this *Benefit Handbook* or in the administration of this *Benefit Handbook*, including utilization review and quality assurance activities;

b. Use in bona fide medical research in accordance with regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects;

c. Use in education within Participating facilities;

d. Where required by law;

e. Health care payments and operations.

6. NOTICE

Any notice to a Member may be sent to the last address of the Member on file with HPHC. Notice to HPHC should be sent to:

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

7. MODIFICATION OF THIS BENEFIT HANDBOOK

This *Benefit Handbook*, the *Schedule of Benefits* and *Prescription Drug Brochure* may be amended by the Plan and the GIC. Amendments do not require the consent of Members.

This *Benefit Handbook* including the *Schedule of Benefits* and *Prescription Drug Brochure*, constitute the entire contract between you and the GIC.

8. RELATIONSHIP OF PARTICIPATING PROVIDERS AND HPHC

The relationship of HPHC to providers, other than HPHC employees, is governed by separate agreements. They are independent contractors. Such Providers may not modify this *Benefit Handbook*, *Schedule of Benefits*, *Prescription Drug Brochure*, or any applicable riders or create any obligation for HPHC. HPHC is not liable for statements about this *Benefit Handbook* by them, their employees or agents. HPHC may change its arrangements with service providers, including the addition or removal of providers, without notice to Members.

For any questions regarding this *Benefit Handbook*, Members may contact HPHC at **1-888-333-4742**.

9. MAJOR DISASTERS

HPHC will try to provide or arrange for services under this Plan in the case of major disasters. These might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of HPHC facilities or the disability of service providers. If the Plan cannot provide or arrange such services due to a major disaster, HPHC is not responsible for the costs or outcome of its inability.

10. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS

HPHC uses a standardized process to evaluate inquiries and requests for coverage received from internal and/or external sources, and/or identified through authorization or payment inquiries. The evaluation process includes:

- Determination of FDA approval status of the device/product/drug in question;
- Review of relevant clinical literature; and
- Consultation with actively practicing specialty care Providers to determine current standards of practice.

Decisions are formulated into recommendations for changes in policy, and forwarded to HPHC management for review and final implementation decisions.

11. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

HPHC uses clinical review criteria and guidelines to make fair and consistent utilization management decisions. Criteria and guidelines are developed in accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least biennially, or more often if needed to accommodate current standards of practice.

HPHC uses the nationally recognized InterQual criteria to review elective surgical day procedures, and services provided in acute care hospitals. InterQual criteria are developed through evaluation of current national standards of medical practice with input from physicians

and clinicians in medical academia and all areas of active clinical practice. InterQual criteria are reviewed and revised annually.

Criteria and guidelines used to review other services are also developed with input from physicians and other clinicians with expertise in the relevant clinical area. The development process includes review of relevant clinical literature and local standards of practice.

HPHC's Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service. Clinician Advisory Committees work in collaboration with Medical Management leadership to develop and approve utilization review criteria.

12. DISAGREEMENT WITH RECOMMENDED TREATMENT

Members enroll in the Plan with the understanding that HPHC Providers are responsible for determining treatment appropriate to the Member's care. Some Members may disagree with the treatment recommended by HPHC Providers for personal or religious reasons. These Members may demand treatment or seek conditions of treatment that HPHC Providers judge to be incompatible with proper medical care. In the event of such a disagreement, Members have the right to refuse the recommendations of HPHC Providers. In such a case, the Plan shall have no further obligation to provide coverage for the care in question. Members who obtain care from non-Participating Providers because of such disagreement do so with the understanding that the Plan has no obligation for the cost or outcome of such care. Members have the right to appeal benefit denials to the Member Appeals Committee (See Section E.2. on page 40).

SECTION J. GLOSSARY

This section lists the words with special meaning in this *Benefit Handbook*.

Activities of Daily Living

The normal functions of daily life, including walking, speaking, transferring, bathing, dressing, continence, and using the toilet. Activities of Daily Living do not include special functions needed for occupational purposes or sports.

Anniversary Date

The date upon which the yearly Plan premium rate is adjusted and benefit changes become effective. This date is typically July 1st.

Behavioral Health Access Center

The organization, designated by the Plan, responsible for coordinating services for Members in need of mental health or substance abuse care. You may call the Behavioral Health Access Center at **1-888-777-4742**.

Benefit Handbook (or Handbook)

This legal document, including the *Schedule of Benefits*, the *Prescription Drug Brochure*, and any applicable riders which set forth the services covered by the Plan, the exclusions from coverage and the conditions of coverage for Members.

Benefit Reductions

Benefit Reductions are the amounts your benefits will be reduced for failure to obtain required Prior Plan Approval or provide Notification for certain services. Benefit Reductions are in addition to any Member Cost amounts and do not count toward the Out-of-Pocket Maximum. Please refer to Sections A.6. and A.7. for a detailed explanation of the Prior Plan Approval and Notification processes.

Centers of Excellence

Certain specialized services are only covered at the In-Network benefit level when received from designated Participating Providers with special training, experience, facilities or protocols for the service. HPHC refers to these providers as "Centers of Excellence."

Centers of Excellence are selected based on the findings of recognized specialty organizations or government agencies such as Medicare. The fact that a facility is a Participating Provider does not mean that it is a Center of Excellence.

Please see Section I.A.9. ("Centers of Excellence") for a list of the services that must be received at a Center of Excellence to be covered as an In-Network service by the Plan. A list of Centers of Excellence may be found in the Provider Directory. Members may view the Provider Directory at WWW.HARVARDPILGRIM.ORG or contact the Member Services Department at 1-888-333-4742 to verify a Provider's status.

Coinsurance

A percentage of the Covered Charge for certain Covered Services that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in this *Benefit Handbook* and the *Schedule of Benefits*.

Copayment

Fees payable by Members for certain Covered Services. Copayments are payable at the time of the visit or when billed by the Provider. Under this Benefit Handbook, the Copayment may vary by type of provider or type of service.

Covered Services

The health care services and supplies for which a Member is covered at the benefit level provided in this *Benefit Handbook* and the *Schedule of Benefits*. Covered Services under this Plan are described in Section I.B. on page 17.

Covered Charges

Expenses incurred by a Member for Covered Services. Covered Charges do not include any amount in excess of a benefit limit stated in this *Benefit Handbook* or in excess of Reasonable Charges.

Custodial Care

Services that are furnished mainly to assist a person in Activities of Daily Living. Examples of such services include: room and board, routine nursing care, help in personal hygiene, and supervision in daily activities.

Deductible

A specific dollar amount that is payable by the Member for Covered Services each calendar year before any benefits are available under this Plan. The Deductible amount is specified in this *Benefit Handbook* and the *Schedule of Benefits.*

Dependent

A Member (other than the Subscriber) covered under the Subscriber's Family Coverage who meets the eligibility requirements for coverage through a Subscriber as agreed upon by the GIC and HPHC.

Enrollment Area

A list of cities and towns where Participating Providers are available to manage Members' *In-Network* care. Members, except for a Dependent child attending an accredited educational institution, must maintain residence in the Enrollment Area and live there at least nine months of the year. HPHC may add cities and towns to the Enrollment Area from time to time.

Experimental or Unproven

A service, procedure, device, or drug will be deemed Experimental or Unproven by HPHC on behalf of the GIC under this *Benefit Handbook*, *Prescription Drug Brochure* and *Schedule of Benefits*, including any applicable riders, for use in the diagnosis or treatment of a particular medical condition if either of the following is true:

a. The service, procedure, device, or drug is not recognized in accordance with generally accepted medical standards as being safe and effective for use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.

   Please note, autologous bone marrow transplants for the treatment of breast cancer, as required by law, are not considered Experimental or Unproven when they satisfy the criteria identified by the Massachusetts Department of Public Health.

b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). This does not include off-label uses of FDA approved drugs.

c. For purposes of the treatment of infertility only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Massachusetts Infertility Benefit Regulations at 211 CMR Section 37.00 et. seq.

Family Coverage

Coverage for a Subscriber and one or more Dependents.

(The) Group Insurance Commission (GIC)

The state agency that has contracted with HPHC to provide health care services and supplies for its employees, retirees and their Dependents under the Plan. The GIC is the sponsor and insures the health care coverage.

Harvard Pilgrim Health Care, Inc. (HPHC)

Harvard Pilgrim Health Care, Inc. is a Massachusetts corporation that is licensed as a Health Maintenance Organization (HMO) in the state of Massachusetts. HPHC provides or arranges for health care benefits to its Members through a network of Primary Care Physicians, specialists and other Providers. Under self insured plans such as this one, HPHC adjudicates and pays claims, and manages benefits on behalf of the GIC.

Hospital

A facility that is licensed to provide inpatient medical, surgical, or rehabilitative services. A Hospital does not include a skilled nursing facility or any place operated primarily to provide convalescent or Custodial/Chronic Care.

Hospital Inpatient Copayment

A Copayment payable for inpatient care. Please refer to the Schedule of Benefits to determine what Covered Services are subject to the Hospital Inpatient Copayment.

Individual Coverage

Coverage for a Subscriber only. No coverage for Dependents is provided.

Individual Practice

An individual doctor who is under contract to provide care to Members.

In-Network

The level of benefits or coverage a Member receives when Covered Services are obtained from a Participating Provider.

Medical Emergency

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to (1) place the health of the Member or another person in serious jeopardy, (2) cause serious impairment to body function, or (3) cause serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate

time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

Medical Group

A group of physicians who are under contract to provide care to Members.

Medically Necessary

Those medical services which are (a) essential for the treatment of a Member's medical condition, (b) in accordance with generally accepted medical practice, and (c) provided at an appropriate facility and at the appropriate level of care for the treatment of a Member's medical condition in accordance with generally accepted standards in the medical community.

Member

Any Subscriber or Dependent covered by this *Benefit Handbook*.

Member Cost

The Member's share of the cost of the benefits provided under the Plan. Member Cost includes Copayments, Coinsurance, Deductibles, Benefit Reductions, charges in excess of the Reasonable Charge, and any combinations of the same. Member Cost differs by the type of benefit and when services are received by Participating and Non-Participating Providers. The Member Cost of specific benefits are listed in this *Benefit Handbook* and in the *Schedule of Benefits*.

Non-Participating Provider

A non-participating provider is a provider with whom HPHC does not have special agreements or contracts.

Non-tiered Providers

Non-tiered Providers include Harvard Pilgrim Providers who have not been rated for quality and/or cost efficiency or assigned to a tier. Please see Section A.2.d. of this Handbook and the *Schedule of Benefits* for detailed information on Non-tiered Providers.

Notification

Notification involves informing HPHC that the member is or will be using certain services. Further information about Notification may be found in Section A.7. on page 15.

Out-of-Network

The level of benefits or coverage a Member receives when Covered Services are obtained from a Non-Participating Provider.

Out-of-Pocket Maximum

The total amount of any combination of Copayments, Coinsurance and Deductible payments a Member pays in a calendar year. Once the Out-of-Pocket Maximum has been reached, no further Copayment or Coinsurance amount will be payable by the Member for the remainder of the calendar year, and the Plan will pay 100% of the Covered Charges. In some instances, a Family Out-of-Pocket Maximum applies. Once a Family Out-of-Pocket Maximum has been met in a calendar year, the Out-of-Pocket Maximum is deemed to have been met by all Members in a Family for the remainder of the calendar year.

Participating Provider

Providers who are under contract to provide care to Plan Members. Participating Providers are listed in the Provider Directory.

Plan

The Harvard Pilgrim Independence Plan, a health benefit plan that administers health care benefits to its Members on behalf of the GIC. The Plan offers coverage under an arrangement whereby Members are provided financial incentives to obtain Covered Services from Participating Providers.

Plan Sponsor

The entity that has contracted with HPHC to provide health care services and supplies for its employees and their Dependents under the Plan. The Plan Sponsor insures the health care coverage. The GIC is the Plan Sponsor of this Plan.

Prior Approval Program

The Plans Program to verify that certain Covered Services are, and continue to be, Medically Necessary and provided in an appropriate and cost effective manner. Further information about the Prior Approval Program, as well as a list of procedures and services requiring Prior Plan Approval, may be found in Section A.6. on page 12.

Prior Plan Approval

HPHC's authorization of Medically Necessary services, as required for certain Covered Services. Further information about Prior Plan Approval may be found in Section A.6. on page 12.

Provider

A Hospital or facility that is licensed to provide inpatient medical, surgical, or rehabilitative services; a skilled nursing facility; and medical professionals including: physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, physician's assistants, psychiatric social workers, certified psychiatric nurses, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialists, licensed mental health counselors, physicians with recognized expertise in specialty pediatrics (including mental health care), nurse midwives, nurse anesthetists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health.

Provider Directory (GIC Provider Directory)

A directory that identifies HPHC Participating Providers.

Qualified Medical Support Order (QMSO)

A court order providing for coverage of a child.

Reasonable Charge

An amount that is consistent, in HPHC's judgment, with the normal range of charges by health care providers for the same or similar products or services in the geographical area where the product or service was provided to a Member. If HPHC cannot reasonably determine the normal range of charges where the products or services were provided, it will utilize the normal range of charges in Boston, Massachusetts. The Reasonable Charge is the maximum amount that the Plan will pay for Covered Services.

Subscriber

The person who meets the eligibility requirements described in this *Benefit Handbook* as determined by the GIC.

Surgical Day Care Copayment

A Copayment that is applicable to Surgical Day Care services. The Surgical Day Care Copayment is indicated in the *Schedule of Benefits* and Section A of this Handbook.

Surgical Day Care

A surgery or procedure in a day surgery department, ambulatory surgery department, or outpatient surgery center that requires operating room, anesthesia and recovery room services.

Tier 1 Copayment

A lower Copayment amount that applies to certain services and highly-ranked Providers. Please see Section A of this Handbook and the *Schedule of Benefits* for detailed information on when the Tier 1 Copayment applies.

Tier 1 Provider

Providers for which a Tier 1 Copayment applies. Please see Section A of this Handbook and the *Schedule of Benefits* for detailed information about Tier 1 Providers.

Tier 2 Copayment

A higher Copayment amount that applies to certain services received from specialty care Providers. Please see Section A of this Handbook and the *Schedule of Benefits* for detailed information on when the Tier 2 Copayment applies.

Tier 2 Provider

Providers for which a Tier 2 Copayment applies. Please see Section A of this Handbook and the *Schedule of Benefits* for detailed information about Tier 2 Providers.

Tier 3 Copayment

The highest Copayment amount that applies to certain Providers, who were rated "standard" based on quality and cost efficiency. Please see Section A of this Handbook and the *Schedule of Benefits* for detailed information on when the Tier 3 Copayment applies.

Tier 3 Provider

Providers, who were rated "standard" based on quality and cost efficiency for which a Tier 3 Copayment applies. Please see Section A of this Handbook and the *Schedule of Benefits* for detailed information about Tier 3 Providers.

II. PATIENT RIGHTS

This section describes your rights as a patient.

As a patient you are entitled by law to the following patient rights from your health care Provider:

- To request and obtain the name and specialty, if any, of the physician or other person responsible for your care or the coordination of your care;
- To have all your medical records and communications kept confidential to the extent provided by law;
- To have all reasonable requests answered promptly and adequately within the capacity of the treating Provider;
- To obtain a copy of any rules or regulations which apply to your conduct as a patient;
- To request and receive any information a Provider has available regarding financial assistance and free health care;
- To inspect your medical records and to receive a copy of your records for a reasonable fee;
- To refuse to be examined, observed, or treated by students or any other staff without jeopardizing access to medical care and attention;
- To refuse to serve as a research subject and to refuse any care or examination the primary purpose of which is educational rather than therapeutic;
- To have privacy during medical treatment within the capacity of the Provider's office;
- To prompt life-saving treatment in an emergency without discrimination based on economic status or source of payment; and without delaying treatment to discuss source of payment, unless delay will not cause risk to your health;
- To informed consent to the extent provided by law;
- To request and receive an itemized copy of your bill or statement of charges, if any, including third party payments towards the bill, regardless of the sources of payment;
- To request and receive an explanation of the relationship, if any, of the physician to any health care facility or educational institutions if this relationship relates to your care or treatment; and
- In the case of a patient suffering from breast cancer, to be provided with complete information on alternative treatments that are medically appropriate.

If you believe that any of your rights have been violated by a Participating Provider, you have the right to file a complaint with HPHC or its designee. All complaints must be submitted in writing and addressed to:

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

For Massachusetts Physicians:

Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
(617) 654-9800

For New Hampshire Physicians:

Board of Medicine
2 Industrial Park Drive
Suite #8
Concord, NH 03301-8520

For Vermont Physicians:

Vermont Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106

For Rhode Island Physicians:

Rhode Island Department of Public Health
Licensure and Discipline
3 Capitol Hill
Providence, RI 02908
(401) 222-2231

For Maine Physicians:

Board of License in Medicine
137 State House Station
Augusta, ME 04333

III. MEMBER RIGHTS & RESPONSIBILITIES

This section describes your rights and responsibilities as a Member.

- Members have a right to receive information about HPHC, its services, its practitioners and Providers, and Members' rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with practitioners in decision-making regarding their health care.
- Members have a right to a candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about HPHC or the care provided.
- Members have a right to make recommendations regarding the organization's Members' right and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that HPHC and its practitioners and Providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.
- Members have a responsibility, to the degree possible, to understand their health problems and participate in developing mutually agreed upon treatment goals.

IV. CONFIDENTIALITY STATEMENT

HPHC is committed to ensuring and safeguarding the confidentiality of its Members' information in all settings, including personal and medical information. HPHC staff access, use and disclose Member information only in connection with providing services and benefits and in accordance with HPHC's confidentiality policies. HPHC permits only designated employees, who are trained in the proper handling of Member information, to have access to and use of your information. HPHC sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to HPHC's confidentiality and privacy standards.

When you enrolled with HPHC, you consented to certain uses and disclosures which are necessary for the provision and administration of services and benefits, such as: coordination of care, including referrals and authorizations; conducting quality activities, including Member satisfaction surveys and disease management programs; verifying eligibility; fraud detection and certain oversight reviews, such as accreditation and regulatory audits. When HPHC discloses Member information, it does so using the minimum amount of information necessary to accomplish the specific activity.

HPHC discloses its Members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your *Benefit Handbook*. Whenever possible, HPHC discloses Member information without Member identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. HPHC will not disclose to other third parties, such as employers, Member-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable law, HPHC and all of its contacted health care providers agree to provide Members access to, and a copy of, their medical records upon a Member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

V. APPENDICIES

APPENDIX A. GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

Group Health Continuation Coverage under COBRA
This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What is COBRA coverage?
COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage contact the GIC's Public Information Unit at (617) 727-2310, ext. 1, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at **www.dol.gov/ebsa.**

Who is eligible for COBRA coverage?
Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth, Municipality, or other entity ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full-time student or ceases to be a full-time student)

How long does COBRA coverage last?
By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage.

You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- Your employer no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?
Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How much does COBRA coverage cost?
Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?
If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I elect other health coverage besides COBRA?
Yes. You may have the right to enroll, within 31 days after coverage ends, in an individual health insurance policy with your current health plan without providing proof of insurability. The benefits provided under such a policy will be different from those provided by the GIC's health plans (including those provided through COBRA). You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**

  – The employee's job terminates or his/her hours are reduced
  – The employee or former employee dies
  – The employee divorces or legally separates
  – The employee or employee's former spouse remarries
  – A covered child ceases to be a dependent
  – The Social Security Administration determines that the employee or a covered family member is disabled, or
  – The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

APPENDIX B. IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

The Centers for Medicare Services requires that this *NOTICE OF CREDITABLE COVERAGE* be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. This notice:

- Applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- Provides information about your GIC-sponsored drug coverage and Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- Explains your options; and
- Tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

Medicare Drug Plans

The Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon *Senior Plan*, or Tufts Health Plan *Medicare Preferred* (formerly *Secure Horizons*), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage pays. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. If your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 (or the month of your 65th birthday, whichever is later) that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.medicare.gov.
- Call the Group Insurance Commission at 1-617-727-2310.

July 1, 2008

APPENDIX C. NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures
We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment Activities – The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations – The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures – The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals)
- to verify agency and plan performance (such as audits)
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- for judicial and administrative proceedings (such as in response to a court order)
- for research studies that meet all privacy requirements
- to tell you about new or changed benefits and services or health care choices

Required Disclosures – The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us – In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights
You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.

- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.

- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research.

- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.

- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.

- Receive a separate paper copy of this notice upon request (an electronic version of this notice is on our web site at www.mass.gov/gic).

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

APPENDIX D. THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)
The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.

- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.

- Service members who elect to continue their GIC health coverage are required to pay the employee share for such coverage.

- USERRA coverage runs concurrently with COBRA and other state continuation coverage.

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Group Insurance Commission.

APPENDIX E. IMPORTANT INFORMATION FROM THE GROUP INSURANCE COMMISSION ABOUT YOUR HIPAA PORTABILITY RIGHTS

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group health plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance at (617) 521-7777 or the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272.

Using Certificates of Creditable Coverage to Reduce Pre-existing Condition Exclusion Waiting Periods
Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as "pre-existing condition exclusions," apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior "creditable" coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act [FMLA] and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage.)

When You Have the Right to Specially Enroll in Another Plan
If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. **Therefore, if you have such a life event or your coverage ends, you should request special enrollment in another plan as soon as possible if you are eligible for it.**

You Have the Right Not to Be Discriminated Against Based on Health Status
A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When You Have the Right to Individual Coverage
If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more.
- Your most recent coverage was under a group health plan (shown on this certificate).
- Your group coverage was not terminated because of fraud or nonpayment of premium.
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

VI. INDEX

This Index provides the location of Covered Services under the Harvard Pilgrim Independence Plan[sm] (the Plan) within the Benefit Handbook. For Covered Services not listed below and for detailed information regarding Covered Services, please read Section B of the Benefit Handbook.

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